NOTE

Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform

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INTRODUCTION

Few groups confront as many barriers to healthcare as transgender patients.[1] Transgender individuals are frequently denied access to health services because of their gender identity or expression, and many report experiencing verbal and even physical harassment in medical offices and hospitals.[2] Those who are able to locate care often find that they cannot actually access services, due to a lack of insurance or financial resources.[3] Even transgender patients with health insurance have difficulty obtaining care. This is particularly true if the care sought is for transition related purposes, since most policies exclude coverage for gender-confirming interventions and surgeries.[4] The transgender population's lack of access to care is all the more striking when considered alongside the group's elevated risk for a number of serious health problems. One study reports, for example, that forty-one percent of transgender individuals have attempted suicide at some point in their lives.[5]

This Note examines the current landscape of transgender healthcare and

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1. I use the terms "transgender," "gender variant," and "gender nonconforming" interchangeably to reference a wide range of people whose self-identity does not conform to the identity or norms usually associated with the sex they were assigned at birth. Some of these individuals may seek medical care to transition to a different sex while others do not. *See* A. Evan Eyler, *Primary Medical Care of the Gender-Variant Patient*, *in* PRINCIPLES OF TRANSGENDER MEDICINE AND SURGERY 15, 19-21 (Randi Ettner et al. eds., 2007) (discussing a range of health treatments sought by transgender patients). I use the term "transsexual" to refer to individuals who seek genital sex reassignment surgery only when the phrase is used in the literature being cited. Like Katharine Franke, I believe the term "transsexual" focuses too much on the alteration of genitalia and ignores the diversity of transgender individuals and their health needs. *See* Katherine M. Franke, *The Central Mistake of Sex Discrimination Law: The Disaggregation of Sex from Gender*, 144 U. PA. L. REV. 1, 32 n.130 (1995). Finally, I refer to the various procedures that alter a transgender patient's physical appearance to reflect the individual's gender identity as "transition-related," "transitional," or "gender-confirming" care.

2. JAIME M. GRANT ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 73-74 (2011), *available at* http://transequality.org/PDFs/

NTDS_Report.pdf (reporting that 19% of a national sample of transgender individuals had been refused care by a medical provider due to their transgender or gender non-conforming status; 28% of respondents experienced verbal harassment in a medical setting; 2% were physically attacked in a doctor's office).

3. Transgender individuals are "less likely than the general population to have health insurance, more likely to be covered by public programs such as Medicare or Medicaid, and less likely to be insured by an employer." *Id.* at 76.

4. *Id.* at 77.

5. *Id.* at 82. Transgender populations also experience extraordinarily high rates of physical violence, sexual assault, and HIV, as well as above average rates of drug and alcohol abuse. *Id.* at 80-81.

coverage and evaluates how the Patient Protection and Affordable Care Act (PPACA), the Obama Administration's landmark health insurance legislation, may change the state of transgender care.[6] Called "the most expansive social legislation enacted in decades,"[7] the PPACA extends health insurance to millions of previously uninsured Americans,[8] extensively modifies public insurance plans, and imposes new requirements on private insurance companies.[9] By eliminating pre-existing condition exclusions and mandating certain essential insurance benefits, the PPACA promises to expand access to care. But for transgender populations, the care promised may not be the care sought. Depending on how it is interpreted and applied, the legislation may secure new medical benefits for transgender individuals, or it may worsen the state of transgender healthcare altogether.

The PPACA's impact on transgender patients will hinge on administrative and legal interpretations of the legislation. Medicine and insurance play a part in determining sexual identities for transgender persons, but importantly, so does law. Legal institutions have traditionally understood sex as immutable, unambiguous, and fixed at birth.[10] The law assumes that sex is binary: an individual can be a man or a woman, but not both or neither.[11] Nevertheless, current medical discourse, along with a growing body of legal scholarship, suggests that for gender-variant populations, sex is not solely defined by biological factors, but is actually "a human-made process, often involving a legal process."[12] The state's role in determining and defining sex compels us to consider how benefits, particularly health benefits, are allocated to or withheld from transgender individuals.

This Note proceeds in three Parts. Part I explores the complicated relationship between transgender medicine and transgender law, which has

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6. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter PPACA].

7 Sheryl Gay Stolberg & Robert Pear, *A Stroke of a Pen, Make That 20, and It's Official*, N.Y. TIMES, Mar. 24, 2010, at A19.

8. *See* Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives tbl. 4 (Mar. 20, 2010), *available at* http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

9. *See, e.g.*, PPACA § 1001, 124 Stat. 130 (instituting individual and group market reforms); PPACA § 2001, 124 Stat. 271 (delineating Medicaid coverage for the lowest income populations).

10. An individual's legal sex is usually determined by the appearance of external genitalia at birth. Julie A. Greenberg, *The Roads Less Traveled: The Problem with Binary Sex Categories*, *in* TRANSGENDER RIGHTS 51, 52 (Paisley Currah et al. eds., 2006).

11. *Id.* at 63. Not everyone can be characterized accurately by self-identification or physical features. Intersex individuals, for instance, sometimes exhibit physical attributes of both sexes and could therefore be classified as neither male nor female or both male and female. *See id.* at 57-63.

12. Noa Ben-Asher, *The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties*, 29 HARV. J.L. & GENDER 51, 53 (2006).

produced the patchwork of inconsistent and disjointed policies that currently regulate sex and gender identity. Courts and legislatures have long relied on medical discourse to justify legal decisions affecting the lives of transgender people.[13] In using medical evidence to dictate the bounds of transgender rights, however, the law fails to adequately consider other aspects of sex that have little to do with anatomy. Developments in transgender law also tend to lag far behind developments in transgender health, suggesting that the gap between medicine and law may be just as concerning as the overlap.

Part II assesses how insurance providers have been able to capitalize on the confusion that results from medical and legal discourses about transgender people, and considers how they have contributed to that confusion themselves. Though courts have sometimes intervened to mandate coverage,[14] insurance coverage for gender-confirming treatments and procedures remains patchy at best. Advocates and legal scholars have produced an extensive body of literature calling for expanded coverage of trans-specific healthcare, but have failed to seriously examine the insurance implications of providing trans-inclusive healthcare.[15] From an insurer's perspective, transgender patients are a politically powerless group with certain medical costs rather than insurable risks. As a result, insurers view curbing coverage for transition-related care through exclusions for pre-existing conditions, experimental or cosmetic interventions, or medically unnecessary procedures as financially sensible and politically harmless. Such exclusions, however, rest on troubling assumptions about the transgender condition and trans-specific care that have gone largely unchallenged to date.[16]

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13. *See, e.g.*, M.T. v. J.T., 355 A.2d 204 (N.J. Super. Ct. App. Div. 1976) (reviewing medical history to determine whether a transgender woman was legally female and so validly married to a male); Richards v. U.S. Tennis Ass'n, 400 N.Y.S.2d 267 (1977) (assessing the medical procedures undertaken by tennis player Renee Richards to determine her legal gender).

14. *See, e.g.*, Pinneke v. Preisser, 623 F.2d 546, 549 (8th Cir. 1980).

15. *See, e.g.*, Ben-Asher, *supra* note 12; Kari E. Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 COLUM. J. GENDER & L. 88 (2002); Susan Etta Keller, *Crisis of Authority: Medical Rhetoric and Transsexual Identity*, 11 YALE J.L. & FEMINISM 51 (1999); Jerry L. Dasti, Note, *Advocating a Broader Understanding of the Necessity of Sex Reassignment Surgery Under Medicaid*, 77 N.Y.U. L. REV. 1738 (2002).

16. For instance, actuaries have assumed that most individuals who identify as transgender would opt to receive sexual reassignment surgery if it were covered. *See* J. Denise Diskin, *Taking it to the Bank: Actualizing Health Care Equality for San Francisco's Transgender City and County Employees*, 5 HASTINGS RACE & POVERTY L.J. 129, 154 (2008). In actuality, many transgender patients avoid such surgery because of its risks, the long and painful recovery period, or simply because they do not view surgical interventions as necessary to transition to a different gender. Harper Jean Tobin, *Against the Surgical Requirement for Change of Legal Sex*, 3 CASE W. RES. J. INT'L L. 393, 399-401 (2007).

Part III analyzes how the new federal healthcare legislation could impact the future of transgender healthcare. Though the PPACA is designed to expand healthcare coverage, the reforms implemented through the legislation may actually constrict access to care for transgender patients. The PPACA's new restrictions against pre-existing condition exclusions, lifetime limits on coverage, and mandates requiring greater patient coverage will force insurers to rely on other techniques to control costs. One option that will remain available even after the PPACA's provisions go into full effect is medical-necessity review. This Note predicts that, as insurers are required to cover a growing number of patients without regard to their health status, insurers will likely designate an increasing number of procedures medically unnecessary. A blanket exclusion of transition-related care may emerge as insurers search for health interventions they can refuse to cover without incurring political backlash.

Still, interpreting the PPACA gives judges and policymakers a rare opportunity to redirect the current distribution of transgender health benefits. This Note concludes by suggesting that courts, legislators, and administrative actors should regulate medical-necessity review to include assessment of the legal and social implications of trans-specific medical interventions along with clinical need. Doing so may assure that the PPACA protects access to meaningful healthcare for transgender citizens as strongly as it secures healthcare for other Americans.

I. MEDICALIZED IDENTITY

Transgender individuals can be described as having "gender identities, expressions, or behaviors" that are inconsistent with social norms associated with their natal sex.[17] Some individuals who identify as transgender demonstrate a desire to adopt a gender different from the one they were assigned at birth, while others rebel against binary gender classifications altogether by adopting features of both genders or completely rejecting gender identity.[18] Transgender people may seek medical treatment to transition to another gender, alter their outward appearance to conform to their chosen gender but refrain from medical procedures, or make no physical changes at all.[19]

Despite the fact that many transgender individuals do not desire transition-related care, legal recognition of transgender individuals remains, for the most part, contingent on evidence of medical transition. This Part examines the

17. Carey V. Johnson et al., *Health Care Issues Among Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) Populations in the United States: Introduction*, 54 J. HOMOSEXUALITY 213, 216 (2008).

18. JASON CROMWELL, TRANSMEN AND FTMS 22-23 (1999); *see also* Guy Trebay, *Giving Voice to the Once-Silent*, N.Y. TIMES, Aug. 12, 2010, at E6.

19. Eyler, *supra* note 1, at 19-21.

relationship between medicine and law in transgender healthcare and assesses the benefits and problems of relying on a medical model for legal rights.

A. Transgender Healthcare

Given the diversity of the transgender population, it is not surprising that healthcare needs and desires vary dramatically among transgender individuals. For some, sex reassignment surgery, hormonal therapy, and other medical and psychological interventions are necessary to fully actualize a chosen, or non-biological, gender identity.[20] Others elect to receive certain transition-related treatments, but forego others for different reasons: full transition may not be desired[21] or medically feasible,[22] financial and health insurance constraints may limit access to services,[23] or physicians willing to perform certain procedures may be difficult to locate.[24] Some transgender patients do not want transition-related services at all, but prefer to receive medical care from physicians who have worked with other gender-variant individuals and understand how to approach non-normative gender expression or behavior.[25] Doctors who have treated transgender patients may be more sensitive to special anxieties about physical exams or aware of environmental features, like unisex restrooms, that can make transgender individuals more comfortable regardless of the treatment they seek.[26]

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20. Medical and psychological discourses frequently refer to this subset of the transgender population as transsexuals, even though the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* has replaced "transsexualism" as a clinical diagnosis with "gender identity disorder." Despite the title change, the definition remains the same. Ben-Asher, *supra* note 12, at 51 n.1. As Jerry Dasti notes, "the term 'transgender' can (and does) encompass transsexuals; the term 'transsexual' does not necessarily encompass all transgender people." Dasti, *supra* note 15, at 1739 n.2.

21. CROMWELL, *supra* note 18, at 22 (describing "transgenderists" as people who "neither want nor desire sex reassignment surgery" even though "they live the majority of their lives in a gender that opposes their biological sex").

22. Medical technology, for instance, has advanced enough to allow surgeons to create fully functioning vaginas, but not penises. *See* Taylor Flynn, *The Ties That (Don't) Bind: Transgender Family Law and the Unmaking of Families*, *in* TRANSGENDER RIGHTS 32, 39 (Paisley Currah et al. eds., 2006).

23. Dasti, *supra* note 15, at 1767-68 ("The cost of sex-reassignment surgery is prohibitively high, placing it out of the reach of many transsexuals . . . .").

24. DEBORAH RUDACILLE, THE RIDDLE OF GENDER 220 (2005) (discussing barriers to adequate healthcare for LGBT patients, including poor physician access, lack of awareness in the medical community about the health concerns of LGBT patients, and the failure of curricula in most medical schools to address LGBT health issues).

25. Eyler, *supra* note 1, at 20.

26. HARVEY J. MAKADON ET AL., THE FENWAY GUIDE TO LESBIAN, GAY, BISEXUAL AND

Physicians with experience in trans-specific care, however, can be difficult to locate and transgender patients often encounter discrimination from doctors rather than understanding. Testimony from transgender individuals indicates that many healthcare professionals routinely refuse to treat even non-transition-related health issues.[27] Robert Eads, for example, a female-to-male transperson with ovarian cancer, visited more than twenty physicians who all refused to treat him because they feared that taking on a transgender patient would harm their practices.[28] Those who are able to access care may find that their insurance plan will not cover treatment for certain illnesses, even if they do not stem from transition. A female-to-male transperson interviewed in 2001, for instance, reported being denied coverage for uterine cancer by his insurance company because the insurer did not "treat uteruses in men."[29] Common health problems that receive routine treatment in other contexts may not receive adequate attention when the patient is transgendered.[30]

TRANSGENDER HEALTH 354 (2007) ("Many transgender patients are extremely sensitive about having their bodies looked at, touched, and prodded. It is common for transgender men to refuse breast and pelvic exams, and for transgender women to refuse testicular and prostate exams. . . . [T]aking the time to establish a solid alliance with the patient over a series of visits is often required before a patient will permit these exams.").

27. Grant, *supra* note 2, at 76. The National Center for Transgender Equality reports that nineteen percent of transgender individuals have been refused care due to their transgender or gender-nonconforming status. *Id.* at 72.

28. SOUTHERN COMFORT (Kate Davis, director and producer, 2001). Eads finally received treatment at the Medical College of Georgia in the last year of his life. But by this point he was diagnosed with stage III or IV cancer, which rendered his surgery and radiation treatments unlikely to be a curative. *See* Caitlin Rockett, *"Southern Comfort" More Than Art, More Than Culture*, TENN. JOURNALIST (Nov. 29, 2007), http://tnjn.com/2007/nov/29/southern-comfort-more-than-art. Though the earlier physicians Eads visited clearly denied him care because he was transgender, refusing to treat a transgender patient for ovarian cancer is not necessarily always motivated by prejudice. Ovarian cancer in its later stages usually has a very poor prognosis, and some doctors may reasonably view treatment at this point as futile or beyond the scope of their knowledge. CAROL L. KOSARY, NAT'L CANCER INST., SEER PROGRAM, SEER SURVIVAL MONOGRAPH: CANCER SURVIVAL AMONG ADULTS: U.S. SEER PROGRAM, 1988-2001, PATIENT AND TUMOR CHARACTERISTICS 137 (L.A.G. Ries et al. eds., 2007), *available at* http://seer.cancer.gov/

publications/survival/surv_ovary.pdf; *see also* Tom Tomlinson et al., *Futile Care in Oncology*, 2 LANCET ONCOLOGY 759, 763 (2001); Antoni Viganó et al., *Clinical Survival Predictions in Patients with Advanced Cancer*, 160 ARCHIVES INTERNAL MED. 861, 861-62 (2000).

29. Jody Marksamer & Dylan Vade, *Recommendations for Transgender Health Care*, TRANSGENDER LAW CENTER, http://www.transgenderlaw.org/resources/tlchealth.htm (last visited Apr. 13, 2011).

30. While discrimination from healthcare providers is a major barrier to meeting the health needs of gender-variant populations, inadequate training and research about gender-variant healthcare is also an issue. In medicine, research is critical to setting guidelines and standards of care. But as one commentator remarks, "research on LGBT issues typically begins and ends with

B. Transgender Law and Medicine: Intersection or Disconnect?

For transgender populations, legal recognition is usually closely tied to medical treatment. Medical and surgical practices often drive the legal construction—and reconstruction—of sex. In most states, the sex designation on documents like birth certificates, driver's licenses, and social security cards cannot be changed without at least some evidence of gender-related medical treatment.[31] Medical evidence is also discussed, often at length, in legal cases involving transgender persons. For instance, in assessing the validity of a marriage between a male-to-female transsexual and her husband, a New Jersey trial court reviewed the facts of the wife's sex reassignment surgery in great detail.[32] The court's opinion upholding the legality of the union included testimony from the woman's doctor who stated that her vagina had a "good cosmetic appearance" and was "the same as a normal female vagina after a hysterectomy."[33] Similarly, in *Kantaras v. Kantaras*, a custody battle between a transman and his ex-wife turned on medical evidence describing Mr. Kantaras' genitalia and testimony about the couple's sex life.[34] Mrs. Kantaras asked the Florida Circuit Court to invalidate her marriage to Mr. Kantaras, and thus terminate his custody rights, on the grounds that Mr. Kantaras was legally female, making their marriage legally untenable under Florida law. To determine Michael Kantaras' legal gender during the union, the court heard extensive testimony describing the transition-related interventions Mr. Kantaras had undergone and his capacity to "consummate" the marriage given his decision not to undergo phalloplasty.[35] As these cases demonstrate, routine legal rights for

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AIDS research." RUDACILLE, *supra* note 24, at 220.

31. Policies permitting gender reclassification on identity documents vary widely, depending on the jurisdiction and type of document in question. In California, for instance, changing the sex listed on a birth certificate requires a letter from a physician confirming that an individual has had at least one of a number of specified gender-related surgeries. Meanwhile, to amend a driver license to reflect a sex change, the New York Department of Motor Vehicles requires a statement from a physician, psychologist or psychiatrist stating that one gender predominates over the other and that the licensee in question is either a male or female. A few states will not alter birth-assigned gender on certain government issued documents under any circumstances. Idaho, Ohio, and Tennessee, for example, will not amend the gender markers on a birth certificate even if an individual has undergone genital surgery. Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731, 733, 735-36 (2008).

32. M.T. v. J.T., 355 A.2d 204 (N.J. Super. Ct. App. Div. 1976).

33. *Id.* at 206.

34. Kantaras v. Kantaras, 884 So. 2d 155 (Fla. Dist. Ct. App. 2004).

35. RUDACILLE, *supra* note 24, at 218 (discussing testimony in *Kantaras* case). Despite the lengthy medical evidence presented, the court denied the validity of the Kantaras' marriage by reading the Florida marriage statutes to permit marriage only between individuals of opposite birth

others can "hinge upon surgical status or medical evidence" when a person is transgender.[36]

Many transgender advocates condemn the fact that legal protections for transpeople usually require medical confirmation of transition. When legal rights are tied to medical procedures, transgender individuals who have no desire to alter their biological sex often remain invisible under the law.[37] Such invisibility can, and often does, have dire consequences. For instance, a transperson who is unable to amend the sex listed on basic identification documents because evidence of genital surgery is required risks "being 'outed' in the job application process."[38] Since few jurisdictions prohibit employment discrimination based on gender identity, possessing identification that reflects current gender status can be critical to economic security.[39]

Even those who do medically transition may find that their bodies still do not meet the standards necessary to adopt a different legal sex. The gender marker on a birth certificate, for instance, can usually only be changed with evidence of specific surgical interventions. New York City's Department of Vital Records will amend the sex listed on a birth certificate only if an individual can demonstrate that he or she has received vaginoplasty or phalloplasty.[40] This policy not only excludes transpeople who have undergone other, more common transitional procedures,[41] but also fails to consider the limits of current medical technology. Doctors often discourage individuals who are transitioning from female to male from pursuing phalloplasty because the surgery "presents significant risks, including permanent loss of orgasmic capability, severe scarring, and irreversible damage to the urethra."[42] Since fully functional vaginas

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sex. The *Kantaras* court recognized that medical science has a central role in determining the marriage rights of "postoperative transsexuals," but found that the appropriate place to weigh such medical evidence was in the legislature, not the courtroom. *Kantaras*, 884 So. 2d at 161.

36. Dean Spade, *Resisting Medicine, Remodeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 30 (2003).

37. There are many reasons why transpeople may reject medical interventions that change their bodies. Some are comfortable with their anatomy and have no desire to surgically alter their sexual features. Others believe that surgical transition stems from social norms regarding gender binaries that ought to be resisted. Finally, some do not believe that the current state of medical technology can create the physical characteristics they desire. CROMWELL, *supra* note 18, at 21-30.

38. Spade, *supra* note 31, at 752.

39. *Id.*

40. 24 RCNY § 207.05(a)(5) (2006).

41. Three out of four transgender individuals surveyed in San Francisco reported using hormone therapy to facilitate their transition, but only fifteen percent indicated that they had undergone any sort of sex reassignment surgery. SHANNON MINTER & CHRISTOPHER DALEY, TRANS REALITIES: A LEGAL NEEDS ASSESSMENT OF SAN FRANCISCO'S TRANSGENDER COMMUNITIES app. B (2003).

42. Flynn, *supra* note 22, at 39.

can be constructed without similar problems, gender reclassification policies that turn on the presence of the "right" genitalia "result[] in far more trans women receiving legal recognition of their identified sex than trans men."[43]

Medicine clearly shapes the legal rights available to transgender individuals, but legal assumptions about sex can influence medical protocol for transgender patients too. The law's understanding of sex is almost always strictly binary: legally, one must be either male or female.[44] Until fairly recently, most medical providers who treated gender-variant individuals also subscribed to this binary conception of sex, despite a significant body of biological evidence suggesting that sex appears in more than just two forms.[45] Medical literature, for instance, has long documented the presence of intersex infants who are born with ambiguous or noncongruent sex characteristics.[46] Surgical intervention to "correct" the genitalia of these children continues to be routine in many places.[47] These surgeries are driven by a desire to "enhance health and well-being [of intersex children] to the greatest extent possible."[48] Since legal identity recognizes only two sexes, not pursuing a normalizing genital surgery early in an intersex child's life is often viewed as medically irresponsible.[49] It is only after this "normalizing" procedure is performed that "the sex that matches the surgically created genitalia is . . . assigned on the birth record."[50]

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43. *Id.*

44. Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 ARIZ. L. REV. 265, 266-67 (1999). Though an individual's designation as male or female can have important consequences on marriage rights, legal identification, and ability to claim protection under employment discrimination statutes, legal definitions of sex are extremely rare. *Id.* at 269-70. New York City used to have an odd exception to the standard binary classification of legal sex. Until 2006, local law in New York City allowed transgender individuals who had undergone sexual conversion surgery to obtain new birth certificates, but the new certificates had no gender marker. 24 RCNY § 207.05(a)(5) (2005).

45. *See, e.g.*, Melanie Blackless et. al., *How Sexually Dimorphic Are We?*, 12 AM. J. HUM. BIOLOGY 151, 161 (2000) (reporting that roughly 1.7% of all infants have intersex characteristics that are chromosomal, anatomical, or hormonal in nature).

46. *See, e.g.*, Keith M. Schneider et al., *Surgical Management of Intersexuality in Infancy and Childhood*, 2 ANNALS SURGERY 255, 255 (1968).

47. Ben-Asher, *supra* note 12, at 60-62.

48. RUDACILLE, *supra* note 24, at 109.

49. Dasti, *supra* note 16, at 1746.

50. Greenberg, *supra* note 10, at 53. Greenberg convincingly argues that socially derived norms may drive the characterization of sex just as much as biology. She writes:

> If the genitalia [of an infant] appear[s] ambiguous, sex is assigned, in part, based on sex-role stereotypes. The presence of an "adequate" penis in an XY infant leads to the label *male*, while the absence of an "adequate" penis leads to the label *female*. A genetic (XY) male with an "inadequate" penis (one that

Conditions that must be met in order to legally transition to another gender may impact treatment choices. If a state requires evidence of a specific surgical intervention before permitting a transperson to change the gender marker listed on a birth certificate, it is possible that the individual will elect to undergo the procedure even if it is not otherwise desired or needed.[51] Legal reasons for pursuing treatment may also influence a physician's protocol when treating transgender patients.[52] The *Diagnostic and Statistical Manual of Mental Disorders IV* requires individuals to demonstrate "strong and persistent cross-gender identification" before they can be diagnosed with gender identity disorder.[53] Legal norms may have informed this requirement; since the law only offers two gender choices, male or female, it might be considered medically irresponsible to support transition-related care that leaves an individual sexually ambiguous.

Legal issues can also directly affect the type of treatment physicians provide to transgender individuals. Mayhem statutes that forbid "the amputation of any body part . . . that might prevent a male-bodied individual from being able to serve as a soldier," for example, have been active in almost every jurisdiction in the United States for centuries.[54] While it is unclear how castration would impact military service, few doctors were willing to test the limits of the laws to perform transition related surgeries until the 1960s. In fact, during the 1950s and early 1960s, the "mayhem statut[e] w[as] the single greatest obstacle faced by every transsexual person in America unable to travel overseas for [gender reassignment] surgery or locate one of the few surgeons willing to flout the law

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> physicians believe will be incapable of penetrating a female's vagina when the child reaches adulthood) is "turned into" a female even it means destroying his reproductive capacity. A genetic (XX) female who may be capable of reproducing, however, is generally assigned the female sex to preserve her reproductive capability, regardless of the appearance of her external genitalia. If her phallus is considered to be too large to meet the guidelines for a typical clitoris, it is surgically reduced, even if it means that her capacity for satisfactory sex may be reduced or destroyed. In other words, men are defined based on their ability to penetrate females, and females are defined based on their ability to procreate.

Id. at 52.

51. Admittedly, there are no existing data that support this claim. Surveys on transgender healthcare usually do not ask about the legal motivations behind decisions to pursue transition related care. Many surveys, articles, and books do, however, discuss the importance of legal identification reflecting an adopted gender to a transgender individual's economic and physical welfare. *See, e.g.*, Spade, *supra* note 31.

52. RUDACILLE, *supra* note 24, at 116.

53. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994) [hereinafter DSM-IV].

54. RUDACILLE, *supra* note 24, at 116.

by performing [the] surgery."[55]

While medicine appears sensitive to legal issues that affect transgender individuals, evidence suggests that the law lags behind medical developments in transgender health. Many medical professionals now recognize that sex determination does not rest on the appearance of genitalia alone and binary sex categories do not encompass the full variety of sexual identities. A host of factors inform an individual's sex, including genetic or chromosomal characteristics, gonadal appearance, internal reproductive morphology, external morphologic sex, genital appearance, hormonal levels, phenotypic characteristics or secondary sex features, assigned sex or gender of rearing, and self-identified sex.[56] Incongruence or ambiguity among these factors occasionally occurs, and a growing body of medical literature suggests that this variation should not necessarily be corrected or ignored.[57] Healthcare providers who work with gender-variant populations are also increasingly likely to consider self-identity when making treatment suggestions.[58] Medical communities are slowly moving beyond a strictly physical and binary understanding of sex, yet the law remains committed to the idea that sexual categories are exclusive, fixed, and based on genitalia alone.

C. Negotiating the Medical Construction of Gender: A Transgender Debate

Despite the medical community's growing understanding of the diversity in gender-variant populations, transgender individuals intensely debate whether medical conclusions about sex and gender should be accepted at all. Many transgender advocates resist the medicalization of gender variance, arguing that the description of transgender people in medical terms leads to an understanding of non-normative gender identity as diseased or disordered.[59] Medical definitions of transgender identity found in manuals like the *Diagnostic and Statistical Manual of Mental Disorders* imply that transgender identity is a mental disorder

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55. *Id.*

56. Greenberg, *supra* note 10, at 54.

57. *See, e.g.*, Bruce E. Wilson & William G. Reiner, *Management of Intersex: A Shifting Paradigm*, 9 J. CLINICAL ETHICS 360, 364 (1998) ("[T]he right of the individual to determine what happens to his or her body has been increasingly asserted."); Joel Frader et al., *Health Care Professionals and Intersex Conditions*, 158 ARCHIVES PEDIATRICS & ADOLESCENT MED. 426, 427 (2004) ("Children have the right to know about their bodies. Professionals and parents should tell children . . . how and why they have anatomical differences from others. The differences should provide opportunities to explore the value of individuality and diversity, not occasions for humiliation and shaming.").

58. Greenberg, *supra* note 10, at 68.

59. *See, e.g.*, Ben-Asher, *supra* note 12, at 58 n.23; Dasti, *supra* note 15, at 1738.

requiring medical treatment.[60] Gender-variant individuals may be unable to secure health benefits unless they are willing to present themselves as diseased or disordered within the narrow confines of this diagnosis.[61]

Others within the transgender community frequently argue that, at least for instrumental purposes, a medical definition of the transgender "condition" is necessary. Without a diagnosis of gender identity disorder, individuals seeking surgical interventions or hormonal treatments to transition would probably be unable to access insurance benefits to pay for the procedures. As one scholar notes, "in the United States . . . it won't be an option to have the state or insurance companies pay for the procedures without first establishing that there are serious and enduring medical and psychiatric reasons for doing so."[62] Furthermore, since legal status for transgender people usually depends on medical evidence,[63] depathologizing gender variance risks eliminating legal rights.

The next Section of this Note analyzes what happens when insurers enter this medicalized identity debate. Insurance providers have largely replaced physicians as the key gatekeepers to transition-related interventions, particularly for low- and moderate-income transgender people who cannot pay for gender-confirming care out of pocket. Coverage practices regarding transitional procedures may therefore have a meaningful impact on the movement to depathologize gender variance.

II. GENDER CONFUSION IN INSURANCE MARKETS

Despite the complex health needs of gender-variant individuals,[64] many lack health insurance or other resources to pay for those needs.[65] Even individuals who have insurance find that most providers refuse to cover transition-related

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60. DSM-IV, *supra* note 53, at 532-38.

61. Benedict Carey, *Psychiatry's Struggle To Revise the Book of Human Troubles*, N.Y. TIMES, Dec. 18, 2008, at A1.

62. Judith Butler, *Undiagnosing Gender*, *in* TRANSGENDER RIGHTS 274, 287 (Paisley Currah et al. eds., 2006).

63. *See supra* notes 31-39 and accompanying text.

64. RUDACILLE, *supra* note 24, at 219 ("[Transgender people] have the highest suicide rate for any demographic group, a very high incidence of depression and other mental health problems, and a very high incidence of substance abuse. They have unique medical needs associated with hormonal therapy (breast cancer in genetic males, for example), sexual reassignment surgery and misdiagnosis for ailments (like ovarian cancer in female to male transsexuals).").

65. A recent national survey of transgender and gender non-conforming individuals found that 19% of the 6450 survey participants lacked any type of health insurance. Grant, *supra* note 2, at 2, 76. An additional 19% of the sample was enrolled in public insurance plans, *id.* at 77, which often do not provide coverage for transition-related care. *See infra* note 146.

care.[66] Some insurers also deny coverage to transgender patients for medical issues unrelated to transition.[67]

This Part evaluates why transgender individuals are regularly denied coverage for the care they seek and assesses the insurance risks that transgender patients may pose to insurers and insurance pools alike. From an insurer's perspective, transgender individuals do not have an insurable interest; rather, they are seeking coverage for a condition they already have that is commonly understood as expensive to treat. Gender variance, moreover, does not provoke the popular sympathy and support that more common health conditions incite. As a result, insurers can classify transition-related care as "medically unnecessary" without much fear of public or political backlash.

Yet transition-related care is not only medically appropriate for many individuals diagnosed with gender dysphoria, it is also, in certain cases, absolutely critical.[68] Gender plays a significant, though often overlooked, role in our daily lives, and an inability to fully assume a certain gender can have dire consequences for an individual's mental health, personal safety, and employment opportunities. Misperceptions of gender variance and transition-related interventions also lead to inaccurate conclusions about the kinds of treatments sought by transgender patients and, as a consequence, the costs associated with treating transgender patients. Transgender patients are not a monolithic group of individuals who are all seeking sex reassignment surgery; many desire, and are effectively treated with, far less invasive and expensive interventions. In many ways, transgender individuals are not quite the insurance risks that many insurers make them out to be.

A. Is Gender Variance an Insurable Interest?

Insurance providers have traditionally protected consumers only from the

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66. *See, e.g.*, *Removing Barriers to Care for Transgender Patients: AMA Resolution Supporting Health Insurance Coverage for Treatment of GID*, GAY & LESBIAN ADVOCATES & DEFENDERS, 2 (2008), http://www.glad.org/uploads/docs/publications/ama-resolution-fact-sheet.pdf (reporting that almost all insurance plans categorically exclude coverage for GID-related medical treatment, through either specific exclusions or by finding GID-related treatments to be cosmetic).

67. Some insurers use transgender status, or even the possibility of transgender status, to avoid covering health problems that are unrelated to gender transition. For example, a lesbian in San Francisco who had breast cancer in one breast decided, in consultation with her physician, to remove both of her breasts in order to lessen the chances of a recurrence. Her insurance company covered the first mastectomy, but "worried that the second breast was 'elective surgery' and that, if they paid for that, it would be setting a precedent for covering elective transsexual surgery." Butler, *supra* note 62, at 283; *see also supra* text accompanying note 29-30.

68. Hong, *supra* note 15, at 92 ("[F]or many who do [desire surgical alignment], denial of medical surgery can lead to depression and even trigger suicidal tendencies.").

risk of uncertain loss.[69] Health insurance, in the strict sense, funds medical care only in the event of an unpredictable illness;[70] an already existing condition is not an insurable risk, but a health problem that must be treated with accumulated savings.[71] Under this framework of health insurance, gender variance will almost never be considered an insurable risk. Gender variance is not an illness that strikes suddenly, but rather a condition that patients are often aware of long before they enroll in an insurance plan.[72] Insurance plans that offer coverage for transition-related care are thus expected to attract transgender patients who enroll just to take advantage of such care, rather than individuals who would like to protect against the occurrence of gender variance. The moral hazard problem predicts that including coverage for transitional interventions in health benefit packages will also encourage gender-variant insureds to consume more of these interventions than they would if insurance providers were not paying for the procedures.

It is not difficult to see why health insurers operating in an unregulated, competitive market would be inclined to exclude transition-related care from their list of covered benefits. Health insurance providers, however, no longer operate in an unregulated climate. It is not an overstatement to classify health insurance today as "a separate species of insurance – distinct in function, and therefore content, from conventional indemnity insurance models."[73] Federal and state insurance regulations limit, and sometimes even prohibit, health insurers from using many of the risk classification tools routinely employed in other insurance markets.[74] Also, unlike other types of insurers, few health insurance

69. George L. Priest, *Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1539 (1987).

70. Kenneth T. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 963 (1963) ("Among people who already have chronic illness . . . insurance in the strict sense is probably pointless.").

71. Priest, *supra* note 69, at 1539.

72. Many transgender individuals are reportedly conscious of their gender variance from a young age. In recent years, as popular awareness of gender variance has increased, there has been a tremendous growth in the number of transgender children treated by clinics specializing in gender-identity disorders for youth. *See* Hanna Rosin, *A Boy's Life*, ATLANTIC, Nov. 2008, at 56, 58. "Children like Brandon are being used to paint a more conventional picture; before they have much time to be shaped by experience, before they know their sexual orientation, even in defiance of their bodies, children can know their gender." *Id.* at 62. This is, however, not true for everyone and many individuals only become aware of their transgender status later in life. Some trans-activists, like Dean Spade, argue that the childhood narrative of gender variance forces acceptance of "some theory of innate sexuality and forecloses the possibility that anyone, gender troubled childhood or not, could transgress sexual and gender norms at any time." Spade, *supra* note 36, at 20.

73. Wendy K. Mariner, *Health Reform: What's Insurance Got To Do with It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 AM. J.L. & MED. 436, 438 (2010).

74. Some state laws, for instance, "prohibit or limit risk rating on the basis of gender, at least in group [health] policies." *Id.* at 441-42. Gender rating is permitted and common, however, in

providers focus exclusively on underwriting risks. In addition to providing coverage for unanticipated health problems, health insurers regularly offer preventative and routine health services to all enrolled members. The inclusion of health services in these insurance policies is a "striking departure from insurance jurisprudence, which has prized the risk spreading function of insurance above all other possible purposes."[75]

Health insurance plans, whether public or private, have evolved from functioning primarily as risk spreading devices to operating mainly as cost spreading vehicles. The principal purpose of health insurance is no longer to underwrite health risks, but to finance healthcare.[76] Under this model, the insurability of a health condition depends not just on whether the condition is the result of an unpredictable illness, but also on whether treating the condition serves a socially beneficial purpose important enough to mandate insurance coverage of the treatment.[77] Gender variance may nonetheless be eligible for coverage under plans that condition coverage on whether a treatment is beneficial, rather than on whether there is a risk for illness.

Even under a social welfare conception of health insurance, healthcare programs still "determine what kind of care should be available to all: what to pay for; how to price it; what sources of revenue to use; what limits to put on which services; and how to encourage the most appropriate care."[78] The next two sections explore how insurers have made such decisions with respect to gender-confirming care.

B. Approaches to Excluding Gender-Confirming Care

This section examines the reasons insurers most frequently give for denying coverage of transitional procedures. Insurers, disciplined by competition and

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other types of insurance, including auto insurance and life insurance. George Lauer, *Gender Rating in Health Insurance Under Review in California*, CAL. HEALTHLINE (Feb. 23, 2009), http://www.californiahealthline.org/features/2009/gender-rating-in-health-insurance-under-review-in-california.aspx.

75. Mariner, *supra* note 73, at 444.

76. *Id.* at 441.

77. A growing number of federal and state laws require insurers to pay for care that was routinely excluded by insurers in the past. Even interventions that are perhaps more cosmetic than medical in nature, like the removal of port-wine stains, are sometimes mandated, in recognition of the fact that such treatment can be socially, if not medically, necessary. *See* Victoria Craig Bunce & J.P. Wieske, *Health Insurance Mandates in the States 2010*, COUNCIL FOR AFFORDABLE HEALTH INS., 12 (2010), www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010.pdf (reporting insurance mandates for port-wine stain elimination in a number of states, including Arkansas, Arizona, California, Colorado, and Connecticut).

78. Mariner, *supra* note 73, at 449.

driven by self-preservation, have long tried to curb costs by barring coverage of pre-existing conditions, cosmetic, or experimental procedures, as well as medically unnecessary interventions.[79] Insurance organizations have restricted coverage of transition-related treatments on all three of these grounds at one point or another.

1. Denials for Pre-existing Conditions

Insurers have sometimes excluded gender-confirming care from healthcare plans by classifying gender variance as a pre-existing condition. A pre-existing condition is generally defined as a health-related problem that exists prior to enrolling in a health insurance plan.[80] A pre-existing condition is no longer a health risk to be insured against, but a definite occurrence that may or may not require treatment. Insurance firms have historically dealt with pre-existing conditions through a number of different strategies. Some companies limit coverage of the pre-existing condition for a specific period of time; insurance benefits will usually cover treatments for new illnesses that appear during this period, but not any care or services related to the pre-existing condition.[81] Other insurance providers increase an individual's premiums to reflect the medical interventions that the individual will likely access to treat the pre-existing condition once insured.[82] Finally, some insurers have used certain pre-existing conditions as grounds for exclusion, either from any kind of health insurance coverage or from coverage of the specific condition for the lifetime of the policy.[83]

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79. *See* David M. Cutler, *A Guide to Health Care Reform*, 8 J. ECON. PERSPECTIVES 13, 18 (1994) (noting "many insurers exclude preexisting conditions from coverage" due to fear of adverse selection or moral hazard); Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1640-41 (1991-1992) (discussing the "long series of ordinary contract disputes over the interpretation of terms such as 'medical necessity' or 'experimental' which determine the coverage of health insurance policies"); James P. Jacobson, *To Pay or Not To Pay, That is the Question: Coverage Disputes Between Health Plans and Members*, 29 HAMLINE J. PUB. L. & POL'Y 445, 448-49 (2007) (discussing exclusions for cosmetic and experimental treatments).

80. Christina M. Finello, *Issues in the Third Circuit: One Word Can Make All the Difference: An Examination of the Third Circuit's Handling of Health Care Insurance Policy Exclusion Clauses for Pre-Existing Conditions*, 48 VILL. L. REV. 1355, 1356-57 (2003).

81. Paul Cotton, *Preexisting Conditions 'Hold Americans Hostage' to Employers and Insurance*, 265 JAMA 2451 (1991) (finding that it is not unusual for an insurer to impose "waiting periods for coverage of preexisting conditions").

82. Robert Pear, *Insurers Offer to Soften a Key Rate-Setting Policy*, N.Y. TIMES, Mar. 25, 2009, at B1 ("Insurance policies [are priced], in part, on the basis of a person's medical condition or history.").

83. Theresa Williams, *"Going Bare": Insurance and the Pre-Existing Condition Problem*, 15

Insurers have often relied on pre-existing condition exclusions to deter consumption of transition-related services.[84] From an insurer's perspective, providing coverage for transition-related interventions invites adverse selection of certain risks. A policy that offers transitional care does not further the interests of insurance firms if only those individuals who are certain to take advantage of transition-related treatments enroll. While it may be tempting to conclude that pre-existing condition exclusions for transgender individuals are warranted in this context, the argument is problematic. Providing coverage for transition-related treatments does not mean that only individuals who are certain to take advantage of those interventions will enroll. The transgender community is quite diverse and the type of medical care sought varies from person to person.[85] A trans-person may be more apt to enroll in an insurance policy that provides coverage for gender-confirming care, but it does not follow that the individual will necessarily elect to have a procedure like sexual reassignment surgery. Transgender identity is unlike many other health conditions in that a diagnosis of gender variance does not automatically require a specific medical intervention.

Pre-existing condition exclusions that target transgender individuals also ignore the critical role that physicians play as gatekeepers to medical services sought by transgender patients. A transgender individual cannot access hormone therapy or sex reassignment surgery just because a health insurance policy covers these interventions; a doctor or surgeon has to approve the desired medical service. The "professional relationship between [the] physician and patient limits the normal hazard in various forms of medical insurance. By certifying to the necessity of [a] given treatment or the lack thereof, the physician acts as a controlling agent on behalf of the insurance companies."[86] If incentivized, physicians may exercise sufficient third-party control over gender-confirming care to alleviate concerns about overconsumption of transition-related interventions.

Pre-existing condition exclusions impede the ability of transgender insureds to access gender-confirming care, but more disturbingly, such exclusions appear to license insurance firms to deny coverage to transgender individuals for other types of care as well. Though exclusions for trans-specific care should not preclude access to insurance coverage for other healthcare services, "some insurance companies maintain a broad definition of 'transition-related' [issues]

J.L. & COM. 375, 375 (1995).

84. Diskin, *supra* note 16, at 136-37. Interestingly, such "exclusions . . . do not forbid coverage of procedures used in medical transition when they are being performed on non-transgender people." *Id.* at 137.

85. *See supra* Section I.A.

86. Arrow, *supra* note 70, at 961.

and create false connections between illness and transition."[87] One insurance company stopped paying for a transgender patient's therapy sessions after discovering through her therapist's case notes that she had undergone sex reassignment surgery.[88] Another insurer denied a transsexual patient coverage for blood tests, physical exams, sinus medication, an emergency room visit for a cut on the hand, and treatment for kidney cysts because of her transgender "condition."[89] Gender status thus may not only bar transgender people from accessing health insurance for transition-related care, it can sometimes keep them from accessing health insurance for any kind of care at all.

2. Exclusions for Cosmetic and Experimental Procedures

When not excluded as part of a pre-existing condition, insurers traditionally have framed gender-confirming care as either cosmetic or experimental, and hence, not insurable.[90] From the insurance industry's perspective, a line must be drawn limiting the number of unessential procedures covered to control healthcare costs. Cosmetic procedures, generally considered optional or elective in nature,[91] and experimental interventions, usually believed to have questionable medical value,[92] typically fall outside this line. Some insurers explicitly restrict coverage for transition-related treatments on the grounds that they are cosmetic or experimental.[93] Others simply rely on contract interpretation to reject claims for gender-confirming care under these categories.[94]

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87. Diskin, *supra* note 16, at 137.

88. The insurer refused to pay for the patient's therapy even though she was receiving treatment for depression and the company had been paying for her psychological care for ten years. Hong, *supra* note 15, at 97 n.42.

89. *Id.* at 97-98.

90. *See, e.g.*, Ben-Asher, *supra* note 12, at 58 (describing attempts by state Medicaid administrations to deny coverage for sex reassignment surgeries by classifying them as "cosmetic" or "experimental").

91. *See* Cristine Nardi, Comment, *When Health Insurers Deny Coverage for Breast Reconstructive Surgery: Gender Meets Disability*, 1997 WIS. L. REV. 777, 784 (defining cosmetic procedure as a procedure intended to enhance a normal structure).

92. Hall & Anderson, *supra* note 79, at 1638 ("The 'experimental' exclusion common in health insurance policies responds to a growing concern that most current medical procedures were adopted without ever having been tested rigorously and that at least some of the procedures commonly used today have limited or no medical value.").

93. *See* HUMAN RIGHTS CAMPAIGN, Health Insurance Discrimination for Transgender People (2011), *available at* http://www.hrc.org/issues/transgender/9568.htm, for examples of transgender insurance exclusions.

94. *See, e.g.*, Davidson v. Aetna Life & Cas. Ins. Co., 420 N.Y.S.2d 450, 451 (Sup. Ct. 1979). The insurance company in this case did not have an express clause in its policy prohibiting coverage for transition-related interventions but it did have a section denying coverage for cosmetic procedures. When a transgender insured tried to obtain coverage for sexual reassignment surgery

The small body of case law dealing with coverage disputes over gender-confirming care indicates that transgender litigants have had varied success in persuading courts that transitional interventions should not be dismissed as cosmetic or experimental. Private insurance claims for hormone therapy and sex reassignment surgery are generally upheld only when there are no explicit exclusions in the insurance contract denying coverage for transition-related treatments.[95] In *Davidson v. Aetna Life & Casualty Insurance Co.*, a transgender plaintiff filed suit against her insurance company for refusing to bear the medical expenses of the sex reassignment surgery recommended by her physician. The insurer argued that because "there is nothing physically wrong with a transsexual's body,"[96] the plaintiff's sexual reassignment surgery was "cosmetic in nature" and thus "not necessary and unreasonable."[97] The court found that sexual reassignment surgery could not be considered strictly cosmetic given its purpose and outcomes: "It is performed to correct a psychological defect, and not to improve muscle tone or physical appearance . . . . While many seem appalled at such surgery, it nevertheless has demonstrated proven benefits for its recipients . . . ."[98]

After *Davidson,* many insurers revised their contracts to insert clauses explicitly rejecting coverage of transition-related procedures in order to sidestep judicial disagreement with their classification of such interventions as cosmetic or experimental.[99] Courts generally view these clauses as "bargained-for contractual term[s] [that] preclude[] further . . . actions against an insurer."[100] However, given that the insurance firm generally holds all of the bargaining power in its relationship with the insured and most transgender patients have little choice as to the provider selected by their employers, "the notion that [these] healthcare policies contain bargained-for terms is a legal fiction."[101]

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under the policy, the insurer refused to pay for the surgery on the grounds that it was a cosmetic procedure ineligible for coverage. *See also* G.B. v. Lackner, 145 Cal. Rptr. 555 (Ct. App. 1978) (describing how the Director of the California Board of Health tried to deny Medicaid coverage to a transgender individual who had undergone sex reassignment surgery based on an assessment that the surgery was cosmetic).

95. Hazel Glenn Beh, *Sex, Sexual Pleasure, and Reproduction: Health Insurers Don't Want You To Do Those Nasty Things*, 13 WIS. WOMEN'S L.J. 119, 153 (1998). Beh argues "courts are likely to find [transition-related] treatment medically necessary and not experimental" under those "contracts that do not expressly exclude sex reassignment surgery and/or hormonal treatment." *Id.*

96. *Davidson*, 420 N.Y.S.2d at 452.

97. *Id.* at 451.

98. *Id.* at 453.

99. Hong, *supra* note 15, at 100.

100. *Id.*

101. *Id.* Insurance contracts are, of course, not invalid just because they are contracts of adhesion. Courts will enforce contract agreements even when one party holds all of the bargaining

The insurance industry's general conclusion—that transitional interventions are cosmetic or experimental—presents several issues that courts and government agencies should consider in regulating health insurance policies. First, a significant body of medical evidence and behavioral science research documenting the efficacy of transition-related interventions casts doubt on some insurers' classification of gender-confirming care as experimental.[102] Medical professionals have been providing transitional treatments to transgender patients for over thirty years and medical advancements in this area demonstrate that interventions like hormonal therapy and sex reassignment surgery are "established treatment[s] . . . in th[e] 'refining' stage, much like coronary bypass surgery."[103] Even state Medicaid agencies have found that such interventions "can be appropriate and medically necessary for some people and . . . [should not be] considered experimental."[104]

Second, transition-related procedures are arguably more akin to reconstructive surgery "performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease" than to cosmetic surgery "performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem."[105] A number

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power as long as the terms of the contract are not unconscionable. *See, e.g.*, Trend Homes, Inc. v. Superior Court, 32 Cal. Rptr. 3d 411, 416-17 (Ct. App. 2008).

102. For discussion about the general acceptance of hormonal therapy and surgical reassignment surgery as appropriate treatments for gender dysphoria, see P.T. Cohen-Kettenis & L.J.G. Gooren, *Transsexualism: A Review of Etiology, Diagnosis and Treatment*, 46 J. PSYCHOSOMATIC RES. 315, 326 (1999); David A. Gilbert et al., *Transsexual Surgery in the Genetic Female*, 15 CLINICS PLASTIC SURGERY 471, 486 (1988); and Donald R. Laub et al., *Vaginoplasty for Gender Confirmation*, 15 CLINICS PLASTIC SURGERY 463, 470 (1988). Acceptance of these treatments does not mean that there are no risks associated with the administration of cross-sex hormones or that every potential side effect of sex reassignment surgery in transgender patients has been detected. *See* Louis J. Gooren & Henriette A. Delemarre-van de Waal, *Hormone Treatment of Adult and Juvenile Transsexual Patients*, *in* PRINCIPLES OF TRANSGENDER MEDICINE AND SURGERY 73, 80-84 (Randi Ettner et al. eds., 2007) (reviewing side effects of hormonal sex reassignment and noting that hormone-dependent tumors are "of particular concern"). Also, appropriate management of transition-related care may be particularly challenging since there is usually no training provided for the treatment of transgender patients in medical school or residency and relatively few resources regarding such care exist. *See* Kathleen A. Oriel, *Medical Care of Transsexual Patients*, 4 J. GAY & LESBIAN MED. ASS'N 185, 193 (2000). Given these caveats, it is fair to say that while transition-related procedures are becoming increasingly well-established in common medical practice, there are circumstances where certain treatments may be controversial and perhaps even experimental. However, insurers can monitor transition-related care to identify these risks, without restricting this care altogether.

103. Eric B. Gordon, *Transsexual Healing: Medicaid Funding of Sex Reassignment Surgery*, 20 ARCHIVES SEXUAL BEHAV. 61, 72 (1991).

104. Smith v. Rasmussen, 249 F.3d 755, 760 (8th Cir. 2001).

105. Nardi, *supra* note 91, at 783-84 (emphasis removed).

of studies indicate neurobiological causes for gender variance, suggesting gender identity is "much less a matter of choice and much more a matter of biology."[106] Though psychosocial and environmental factors can influence gender identity, genetic, hormonal, and physiological factors appear to play a significant role as well, thereby distinguishing gender variance from strictly cosmetic conditions.[107] The decision to pursue gender-confirming care, moreover, is not exclusively at the discretion of the patient; doctors impose stringent requirements on transgender patients that have no real parallel in most other treatment contexts.[108] Finally, once one considers the physical and social consequences of transition-related treatment, it is difficult to see it as cosmetic in nature. Hormone therapy and sex reassignment surgery do not simply enhance ordinary biological features: they radically change the anatomy and biological function of patients' bodies. Transitioning to a different gender, moreover, can put family relationships, friendships, and employment at risk.[109] Few undergo this "long and arduous" procedure just to improve their appearance or self-esteem.[110]

Insurance providers sometimes also argue that transition-related interventions are purely cosmetic because they alter "normal" features that are

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106. Frederick L. Coolidge et al., *The Heritability of Gender Identity Disorder in a Child and Adolescent Sample*, 32 BEHAV. GENETICS 251, 251-57 (2002); *see also* Gender Identity Research and Education Society, *Atypical Gender Development – A Review*, 9 INT'L J. TRANSGENDERISM 29, 38 (2006) (describing how scientific evidence supports the paradigm that transsexualism is strongly associated with the neurodevelopment of the brain). It is clear that the condition cannot necessarily be overcome by "consistent psychological socialisation as male to female from very early childhood, and it is not responsive to psychological or psychiatric treatments alone." *Id.* (internal quotations removed).

107. *See* Gender Identity Research and Education Society, *supra* note 106, at 42 (citing Pamela Connolly, Psychologist, Lecture at the Annual Conference of the Harry Benjamin Int'l Gebder Dysphoria Ass'n, Ghent, Belgium: Transgendered Peoples of Samoa, Tonga and India: Diversity of Psychosocial Challenges, Coping, and Styles of Gender Reassignment (Sept. 2003)).

108. To qualify for sex reassignment surgery, a patient must show "(1) [a] recommendation in writing by two behavioral scientists, one of whom has known the patient in a therapeutic relationship for 6 months; (2) a successful cross-living test over a 1-year period; and (3) legal, social, psychological, sexual and (exogenous) endocrine success during cross-living." Beh, *supra* note 95, at 152.

109. Gender Identity Research and Education Society, *supra* note 106, at 31.

110. Beh, *supra* note 95, at 154 (discussing Davidson v. Aetna Life & Cas. Ins. Co., 420 N.Y.S.2d 450 (Sup. Ct. 1979)) ("The court also explained that the arduous and radical procedure was rarely sought and even more infrequently done, implying that it was never done for cosmetic purposes . . . ."); *see also* G.B. v. Lackner, 145 Cal. Rptr. 555, 558 (Ct. App. 1978) ("Surely, castration and penectomy cannot be considered surgical procedures to alter the texture and configuration of the skin and the skin's relationship with contiguous structures of the body. Male genitals have to be considered more than just skin, one would think." (citing definition of cosmetic surgery adopted by California Department of Health)).

fully functional.[111] This claim might have some merit if insurers covered only function-restoring medical interventions treating physical deformities. Insurance policies, however, regularly cover procedures that reconstruct physical appearance but do not result in any new functional capacity, like surgeries implanting prosthetic eyes and breast reconstruction following a mastectomy.[112] Biologically, these procedures have no functional outcome, but they are generally viewed as improving quality of life in a way that distinguishes them from strictly cosmetic interventions. Gender-confirming care has a similar, and oftentimes even more dramatic, impact on personal satisfaction and life outcomes.[113]

It is perhaps best, then, to think of transition-related procedures as medically necessary despite having certain cosmetic features. One problem with this conception of transitional interventions, however, is that non-transgender patients regularly seek these same interventions for what insurance providers consider aesthetic purposes.[114] To insurers, a treatment is presumptively cosmetic, and hence uninsurable, when it is *ordinarily* "directed at improving the patient's appearance."[115]

However, interventions that are regarded as cosmetic in certain contexts should not necessarily be considered cosmetic in all contexts. Transgender patients do not pursue treatments that alter their physical features to simply improve their looks, but rather to "cure or mitigate the distress and maladaption caused by [gender identity disorder]."[116] Such procedures may be required to "'pass' convincingly in public"[117] as a member of the opposite sex, acquire legal

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111. Pinneke v. Preisser, 623 F.2d 546, 549 (8th Cir. 1980) ("The Iowa Department of Social Services established an irrebuttable presumption that the procedure of sex reassignment surgery can never be medically necessary when the surgery is a treatment for transsexualism and removes healthy, undamaged organs and tissue.").

112. Nardi, *supra* note 91, at 783.

113. Anne A. Lawrence, *Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery*, 32 ARCHIVES SEXUAL BEHAV. 299, 299 ("232 male-to-female transsexuals operated on between 1994 and 2000 . . . reported overwhelmingly that they were happy with their SRS [sexual reassignment surgery] results and that SRS had greatly improved the quality of their lives."); *see also* Jamil Rehman et al., *The Reported Sex and Surgery Satisfactions of 28 Postoperative Male-to-Female Transsexual Patients*, 28 ARCHIVES SEXUAL BEHAV. 71 (1999) (reporting greater satisfaction in quality of life and more psychological stability among most of the post-operative transsexual patients surveyed).

114. Transgender as well as non-transgender individuals regularly seek rhinoplasty, for example.

115. I.R.C. § 213(d)(9)(B) (2006) (defining cosmetic surgery, which does not qualify as deductible medical care under the U.S. tax code). How the federal government views a procedure in the tax code can influence how insurers, particularly public insurers, treat the procedure for coverage purposes.

116. O'Donnabhain v. Comm'r, 134 T.C. 34, 92 (2010).

117. *Id.* at 43.

recognition of one's "true" gender, and alleviate the internal discord that may arise when one's gender identity does not align with one's anatomical features.[118] Certain interventions may therefore be medically necessary for transgender populations even though the same treatments are perhaps more appropriately classified as cosmetic for other patient groups.

Still, for transgender patients, instances may arise where it is difficult to distinguish between medically necessary transitional procedures with cosmetic aspects and elective cosmetic procedures with transitional aspects. Public as well as private insurers do not fund cosmetic surgery in part because the aim of cosmetic surgery is usually to produce an aesthetic ideal, not to treat a medical condition. Though transgender patients may pursue surgical interventions primarily to transition to a new gender, they are not immune to the same desires for physical perfection that can motivate other individuals to obtain cosmetic surgery.[119]

While sometimes it may be difficult to police the line between transition and perfection, it is not impossible to do so. A recent ruling by the United States Tax Court provides an example of how medically necessary transition-related interventions can be distinguished from largely cosmetic procedures. In *O'Donnabhain v. Commissioner*, the Tax Court held that a transgender woman's medical expenses for hormone therapy and sex reassignment were tax-deductible because the interventions treated "the distress and suffering occasioned by GID" and "accordingly are not 'cosmetic surgery'" under the tax code.[120] The Court, however, ruled that the petitioner could not deduct expenses for her breast augmentation surgery because hormone treatment before the surgery had already produced breasts "within a normal range of appearance."[121] Her breast augmentation surgery "merely improved her appearance" and thus fell squarely within the definition of cosmetic surgery "excluded from deductible 'medical care.'"[122] As this case demonstrates, accepting the proposition that transition-

118. *See* AM. MED. ASS'N HOUSE OF DELEGATES, RESOLUTION 114, REMOVING BARRIERS TO CARE FOR TRANSGENDER PATIENTS (June 16, 2008), *available at* www.ama-assn.org/ama1/pub/upload/mm/471/114.doc.

119. Transgender individuals who see many transition related procedures as medically necessary still acknowledge that the "line between 'medically necessary' and 'elective'" can become blurry. One transwoman contemplating rhinoplasty remarked, "I don't want it to be the case where I'm always looking for the next procedure to feel more complete—to be the person I should be. I want to get to the point where I'm happy with myself." Amanda Hess, *When Gender Transition Requires a Long, Strange Trip*, SEXIST (July 30, 2009, 10:17 am), http://www.washingtoncitypaper.com/blogs/sexist/2009/07/30/when-gender-transition-requires-a-long-strange-trip.

120. 134 T.C. at 70.

121. *Id.* at 73.

122. *Id.*

related procedures are generally medically necessary does not preclude insurers from rejecting certain interventions as cosmetic, and ineligible for coverage.

3. Medical-Necessity Review

Both public and private insurers attempt to control healthcare costs by refusing coverage for procedures they believe are not "medically necessary."[123] Medically unnecessary interventions include, but are not limited to, procedures insurers conclude are cosmetic or experimental. The medical-necessity requirement is at once the broadest and least defined exclusion clause in most insurance plans.

Medical-necessity review has played a major role in determining whether transgender Medicaid recipients receive access to transitional care. Medicaid is a state-run program funded with federal and state dollars that provides medical insurance to low-income individuals.[124] States have significant discretion in determining which services they will provide under the Medicaid Act, which requires only that the standards adopted for determining the extent of medical assistance be "reasonable" and "consistent with the objectives" of the Act.[125] As long as states follow a "formal" rulemaking process, they are free to exclude certain interventions as medically unnecessary.[126] Because rulemaking procedures are not necessarily consistent across states, different decisions may result about which procedures are eligible for Medicaid coverage and which are not.

Most states have restricted Medicaid coverage for at least some transition-related interventions on medical-necessity grounds. A survey conducted by the Iowa Department of Human Services found that forty states do not fund sex reassignment surgery through Medicaid.[127] In *Smith v. Rasmussen*, the Eighth Circuit upheld Iowa's refusal to fund sex reassignment surgery, acknowledging that while the surgery "may be medically necessary in some cases," the "availability of other treatment options" for gender identity disorder and "lack of consensus in the medical community" about the efficacy of the surgery permits states to refuse coverage for the intervention under Medicaid.[128] The appellate court also cited fiscal concerns as a valid reason to reject coverage of surgical

123. "Medical necessity" does not mean life-or-death necessity; it refers to medically appropriate or medically beneficial treatment. The intent of the standard is to exclude coverage for care that is harmful, of no benefit, or nonstandard. *See generally* Dallis v. Aetna Life Ins. Co., 574 F. Supp. 547 (N.D. Ga. 1983) (discussing the meaning of the term "necessary"), *aff'd*, 768 F.2d 1303 (11th Cir. 1985).

124. 42 U.S.C. § 1396 (2006).

125. Beal v. Doe, 432 U.S. 438, 441 (1977) (quoting 42 U.S.C. § 1396a(a)(17) (1970)).

126. Smith v. Rasmussen, 249 F.3d 755, 760 (8th Cir. 2001).

127. *Id.* at 761 n.5.

128. *Id.* at 760.

interventions that facilitate transition.[129]

Some courts have been less willing to accept broad restrictions against transition-related interventions in Medicaid programs. Courts rejecting statutory or regulatory bans on sex reassignment surgery contend that such bans violate federal Medicaid regulations by arbitrarily imposing restrictions on "the amount, duration, or scope of a required service . . . solely because of diagnosis, type of illness or condition."[130] In *Doe v. Minnesota Department of Public Welfare*, for example, the Minnesota Supreme Court found, "the total exclusion of transsexual surgery from eligibility for [medical assistance] benefits [was] void" because the ban was "directly related to the type of treatment involved" rather than to an evaluation determining whether the intervention was medically necessary.[131] What is most interesting about the *Doe* decision, and many other decisions invalidating state Medicaid bans on sex reassignment surgery, is the court's finding that sex reassignment surgery is the "only medical procedure known to be successful in treating the problem of transsexualism."[132] Cases overturning Medicaid restrictions against sex reassignment surgery, as well as cases upholding them, understand the medical necessity of the intervention as turning on whether or not there are other treatments for gender disorder.

Whether this is actually the right approach to assessing the medical necessity of transition-related interventions is, at best, questionable. A medical-necessity standard that mandates coverage of an intervention only if it is "the only successful treatment known to medical science"[133] is inconsistent with the way medical necessity is generally defined and interpreted. Insurers and courts alike usually deem a medical intervention to be "necessary" when an attending physician finds it to be medically appropriate and the physician's judgment is in line with the medical community's recommended treatments for the condition.[134] Doctors widely recognize mental health services, hormonal therapy, and many sex reassignment surgeries as effective in treating gender variance. The American Medical Association, arguably the leading authority on the appropriateness of medical interventions, formally announced its support for gender-confirming care in 2008, citing that "medical literature has established the effectiveness and *medical necessity* of mental healthcare, hormone therapy, and sex reassignment surgery in the treatment of patients diagnosed with [gender

129. *Id.* at 760-61.

130. Rush v. Parham, 625 F.2d 1150, 1157 n.12 (5th Cir. 1980) (citing 42 C.F.R. §440.-230(c)(1)).

131. Doe v. Minn. Dep't of Public Welfare, 257 N.W.2d 816, 820 (Minn. 1977).

132. *Id.* at 819.

133. *Id.*

134. Hall & Anderson, *supra* note 79, at 1647 n.32, 1649-50.

identity disorder]."[135]

Despite widespread endorsement of transition-related interventions in the medical community, insurers as well as courts remain skeptical of their medical necessity for several reasons. First, the cost of providing gender-confirming care can seem prohibitively expensive; "costs as high as $75,000 per person have been cited as justification for exclusion" of transition-related health benefits.[136] In this era of escalating healthcare costs, attempts to control costs through medical-necessity determination are understandable and should be encouraged. Insurers and occasionally courts play an important gate-keeping function to medical services by checking physicians' incentives to find every procedure "medically necessary," and in so doing make insurance more affordable for everyone.[137]

The experience of insurers who have covered transition-related care suggests, however, that the expense of providing transitional treatments is lower than insurers might imagine.[138] San Francisco, for instance, found that the cost of providing coverage for transition-related interventions was much lower than had been anticipated when it began providing health benefits that covered the costs of hormone treatment, psychotherapy and surgical procedures in 2001.[139] Actuaries had estimated that thirty-five of the city's thirty-seven thousand employees would use the new benefits in the first year they were available to access gender reassignment surgery at a cost of $1.75 million to the city.[140] Actual claim data released in 2005 showed that only eleven claims for transition-related surgery

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135. AM. MED. ASS'N, *supra* note 118 (emphasis added). But note that less than a third of all practicing physicians belong to the AMA. Joseph Shapiro, *Poll Finds Most Doctors Support Public Option*, NPR (Sept. 14, 2009), http://www.npr.org/templates/story/story.php?storyId=112818960.

136. Mary Ann Horton, The Cost of Transgender Health Benefits (2008) (unpublished report) (on file with author), *available at* http://www.tgender.net/taw/thbcost.html.

137. Hall & Anderson, *supra* note 79, at 1663, 1674.

138. In 1997, the San Francisco Human Rights Commission estimated the costs of a variety of transition related medical treatments. The San Francisco Human Rights Commission found that hormone treatments for male-to-female patients (usually PremarinTM) cost between $200 and $500 per year, while different kinds of vaginoplasty ranged in price from $1,350 to $30,000. Hormone treatments for female-to-male patients were estimated to cost between $70 and $540 per year. Some female-to-male individuals also spend $4,000-$7,000 on a bilateral mastectomy, $4000-$18,000 on a hysterectomy and oophorectomy, and anywhere from $5,500 to $38,000 for either a phalloplasty or metoidoplasty. Diskin, *supra* note 16, at 141 (citing S.F. HUMAN RIGHTS COMM'N, INSURANCE COVERAGE FOR TRANSSEXUAL EMPLOYEES OF THE CITY AND COUNTY OF SAN FRANCISCO (1997)); *see also* Benefit Update, City and County of San Francisco, San Francisco City and County Transgender Health Benefit 2 (Mar. 31, 2006), *available at* http://www.tgender.net/taw/SanFranciscoTGBenefitUpdateMar3106.pdf (reporting that City's actuaries estimated thirty five eligible members of the member population would spend $50,000 on transition related care annually).

139. Rachel Gordon, *S.F. to Finance Staff Sex-Changes*, S.F. CHRON., May 1, 2001, at A1.

140. Diskin, *supra* note 16, at 154.

were filed between July 1, 2001, when benefits first went into effect, and July 30, 2004.[141] Financing gender reassignment surgery for transgender employees cost the city only $182,374 *over four years*, far less than officials had projected for a single year in 2001.[142]

Another reason that many insurers and courts question the medical necessity of gender-confirming care may have to do with the fact that not all transgender individuals seek transition-related interventions. It is difficult to justify health expenditures for a "condition" that is not always treated with medicine, particularly as transgender individuals themselves sometimes resist the notion that medical interventions are necessary to "correct" non-normative gender identities.[143]

In truth, there is no one-size-fits-all treatment for gender variance. This does not mean, however, that transition-related procedures are not medically appropriate interventions for some transgender individuals. Few patient groups have uniform health needs and transgender individuals are no exception. Though some transgender people do not access transition-related care, others find medically facilitated transition vital to their mental health and quality of life. Physical features play an enormous, complex, and often understated role in one's own understanding of gender identity as well as society's perception of gender. Incongruence between physical appearance and gender identity can cause severe psychological distress and limit some transgender individuals' "ability to function and survive in society, given current biases and beliefs."[144]

The issue of health insurance coverage for transition-related care will not be resolved by a medical-necessity standard that bases access to a transitional intervention on evidence that it is the "only medical procedure known to be successful in treating the problem of transsexualism."[145] Instead, insurance companies, the courts, and government agencies must articulate a consistent policy recognizing the diversity of health needs among transgender individuals, which renders transition-related treatments medically necessary for some gender-variant patients.

C. Categories of Coverage for Transition-Related Care

Just as there is no single treatment protocol that meets the needs of all transgender patients, there is no one uniform insurer response to claims related to gender transition. While many insurers explicitly deny coverage for transition-

141. *Id.* at 159.

142. *Id.*

143. Dasti, *supra* note 15, at 1743; *see also supra* Section I.C.

144. Keller, *supra* note 15, at 72.

145. Doe v. Minn. Dep't of Public Welfare, 257 N.W.2d 816, 822 (Minn. 1977).

related services,[146] a small number of insurance firms have begun to provide some transitional benefits.[147] The insurers that do cover transitional care, however, rarely support all medical interventions related to sex reassignment.[148] Health insurance providers that fund gender-confirming care are more apt to do so when a particular intervention seems relatively low-cost and is routinely accessed by other patients to treat medical problems unrelated to transition.

The transitional treatments most frequently covered by insurance providers are mental health services and hormone replacement therapy. Compared to other types of gender-confirming care, mental health counseling and hormone treatments appear to be fairly inexpensive: one year of hormone replacement therapy for a female-to-male (FTM) patient can cost as little as $229 while the average price of primary, or "top," surgery for the same patient is approximately $8500.[149] Figures like these, however, hide the fact that mental health therapy and hormonal interventions are rarely single-dose treatments and may, over a patient's lifetime, be more expensive than a one-time surgical procedure. Transgender patients are also more likely to seek mental health and hormone treatments than other transitional interventions, so it may be more costly overall to finance these treatments than pricier, but less utilized, procedures like surgery. Cost seems to be a factor, but not the driving factor, explaining why certain kinds of transition-related treatments are covered and others are not.

One factor that does seem critical for obtaining coverage for gender-confirming care is the availability of an intervention for non-transitional purposes. Though insurers do not explicitly condition transition-related benefits

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146. Many states do not permit individuals to use Medicaid benefits to fund transition related care. *See, e.g.*, Regs. Conn. State Agencies § 17b-262-612(k) (2006) ("The department [of health] shall not pay for the following: . . . transsexual surgery or for a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis."). The federal Medicare statute explicitly excludes coverage for "transsexual surgery" or "sex reassignment surgery . . . [b]ecause of the lack of well controlled, long-term studies of the safety and effectiveness of the surgical procedures and attendant therapies for transsexualism." 54 Fed. Reg. 34,572 (Aug. 21, 1989). The American Civil Liberties Union reports that most private insurance companies "either expressly exclude many forms of transition-related services or are unclear about whether such services are covered." *Know Your Rights-Transgender People and Law*, ACLU (Nov. 19, 2009), http://www.aclu.org/hiv-aids_lgbt-rights/know-your-rights-transgender-people-and-law.

147. *See, e.g.*, *Clinical Policy Bulletin: Gender Reassignment Surgery*, AETNA, http://www.aetna.com/cpb/medical/data/600_699/0615.html (last modified Mar. 25, 2011).

148. Electrolysis, for instance, is generally excluded as cosmetic in nature, even though it may be medically necessary for some transgender patients. *See, e.g.*, *Clinical Policy Bulletin: Cosmetic Surgery*, AETNA, http://www.aetna.com/cpb/medical/data/1_99/0031.html (last modified March 22, 2011).

149. Horton, *supra* note 136, at 3, 7, 11. Horton defines primary top surgeries for FTM patients to include bilateral mastectomy and chest reconstruction.

on whether a treatment is used by other patients for other purposes, almost all covered transitional therapies are regularly prescribed in other contexts. One reason for this may be that insurers are more familiar with, and therefore more accepting of, transition-related treatments frequently used for purposes other than transition. Insurers might more readily approve claims for hormone treatments that facilitate transition, for instance, because such treatments are also regularly used to alleviate more common conditions that stem from menopause, prostate cancer, and growth hormone deficiencies.[150] It can also be easier to obtain coverage for transition-related care when such care serves multiple functions for a patient, at least one of which is treating an approved condition. If an insurance policy routinely covers mental health services for depression, for example, a transgender patient suffering from depression may be able to bill his insurance company for counseling services treating both conditions even if trans-specific care is not covered under the policy.[151] Finally, patients may be able to avoid coverage restrictions against trans-specific care by masking the fact that a treatment with multiple purposes is being used for transition. Most insurance plans reportedly cover around eighty percent of hormone prescriptions for a patient in the maintenance, as opposed to the transition, period of hormone therapy because, as one paper notes, "the patient is documented as their new gender."[152] A male gender marker may help a female-to-male transgender patient access testosterone with little question from a new insurer who knows nothing about the patient's gender history and believes the hormone is being used for approved purposes.

The availability of an intervention for non-transitional purposes may be necessary to obtain coverage for gender-confirming care, but it is hardly sufficient to receive such care under most health insurance policies. Surgical interventions facilitating transition are much less likely to be covered, even if the same surgery is covered for other conditions. Hysterectomies—the most commonly performed gynecological surgery—are routinely covered to treat even

150. *See Health Guide: Growth Hormone Deficiency*, N.Y. TIMES (Sept. 13, 2009), http://health.nytimes.com/health/guides/disease/growth-hormone-deficiency/overview.html; Mayo Clinic Staff, *Hormone Therapy: Is it Right for You?*, MAYO CLINIC (Feb. 19, 2010), http://www.mayoclinic.com/health/hormone-therapy/WO00046 (discussing hormone replacement therapy to treat menopause); *Prostate Cancer Treatment*, NATIONAL CANCER INSTITUTE, http://www.cancer.gov/cancertopics/pdq/treatment/prostate/Patient/page4 (last modified Nov. 5, 2010).

151. Some insurance policies, however, explicitly exclude psychiatric treatment for gender dysphoria from coverage. Testimony from a number of transgender patients indicates that any mention of gender variance in a case file can make obtaining coverage for mental health counseling, even for a condition unrelated to gender variance, nearly impossible under these policies. *See* Hong, *supra* note 15, at 97.

152. Horton, *supra* note 136, at 8.

relatively benign gynecological conditions.[153] Transgender patients who seek the surgery for transitional purposes, however, often find the intervention foreclosed by policy exclusions for sex reassignment surgery or dismissed by the insurer under restrictions banning cosmetic, experimental, or medically unnecessary treatment.[154]

Treatments with no application other than facilitating transition are almost never covered by insurance. Even insurers with trans-inclusive policies that fund "medically necessary" surgical procedures deny coverage for these trans-specific interventions. A transgender patient with a trans-friendly policy will generally have a better chance of obtaining coverage for breast reconstructive surgery, which is regularly performed on women with breast cancer,[155] than for facial feminization surgery, which is virtually never conducted on anyone other than transgender individuals.[156] Transgender patients themselves, however, sometimes view interventions like facial feminization surgery as more essential to transition than procedures aimed at altering primary or secondary sex characteristics.[157]

Finally, procedures explicitly barred for non-transgender policyholders are usually excluded from coverage for transgender policyholders as well. Insurance companies generally view electrolysis, used to remove unwanted facial and body hair, as a strictly cosmetic procedure, and therefore ineligible for coverage under any circumstance.[158] While most patients probably do seek electrolysis for cosmetic reasons, transgender individuals may rely on the procedure to transition to a new gender. Some male-to-female patients view permanent removal of androgen-driven hair, particularly facial hair, as vital to reducing the dissonance between their true gender and the gender assigned to them at birth.[159] Facial hair

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153. *See, e.g.*, *Cigna Medical Coverage Policy: Hysterectomy*, CIGNA, 4-8 (effective April 15, 2010), http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0128_coveragepositioncriteria_hysterectomy.pdf (listing indications/conditions for which hysterectomy is covered).

154. *See* AM. MED. ASS'N HOUSE OF DELEGATES, RESOLUTION 122 (A-08): REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS 2 (2008), *available at* http://www.tgender.net/taw/ama_resolutions.pdf.

155. Women's Health and Cancer Rights Act of 1998, 29 U.S.C. § 1185b (2006) (requiring health insurance companies and self-insured group health plans that cover mastectomies to provide benefits for breast reconstruction surgery).

156. *See* FACIAL FEMINIZATION SURGERY, http://www.facialfeminizationsurgery.info (last visited Dec. 6, 2010).

157. *See, e.g.*, *Facial Feminization Procedures 2010 Update*, TRANSSEXUAL ROAD MAP (Jan. 4, 2011), http://www.tsroadmap.com/physical/face/facesurgidx.html (transgender individual who has had facial feminization surgery stating, "If being accepted as female is your goal, one of the most important things to consider is facial feminization surgery . . . . I feel the key to being accepted as female is from the neck up.").

158. *See, e.g.*, Clinical Policy Bulletin: Cosmetic Surgery, *supra* note 148.

159. *Hair Removal*, TRANSSEXUAL ROAD MAP (Apr. 29, 2011), http://www.tsroadmap.com/

can be a "constant reminder of . . . masculinity." As one trans-woman writes, "facial hair is so masculine a trait that I feel uncomfortable about having a relationship and waking up in company with a five o'clock in the morning shadow."[160]

As this remark indicates, for most individuals gender is not merely about self-identification; how others perceive gender often has an enormous impact on how you understand your own gender. "Passing" as well as one can in a chosen gender is therefore very important to some transgender people.[161] For transgender women seeking to "pass" while out in public, electrolysis is often "the most important thing they do to become passable."[162] Since the visibility of facial hair makes it "one of the strongest male gender cues," failing to remove it puts transgender women at risk of being "outed," or being perceived by others as male. Without procedures like electrolysis, public acceptance of an adopted gender is often extremely difficult.

Covering these procedures for transgender patients, however, can lead to difficult issues for insurers. Interventions like electrolysis are popular among non-transgender individuals, and it might be difficult for insurers to justify covering them for only gender-variant populations, particularly when a non-transgender patient's motivation for pursuing a particular procedure is not that different from a transgender patient's reason. Would funding electrolysis for

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physical/hair. For some transgender patients, permanent hair removal is more vital to transition than other procedures that are more likely to be covered by insurers, like genital reconfiguration. *When in My Transition Should I Start Hair Removal?*, TRANSSEXUAL ROAD MAP (Jan. 4, 2011), http://www.tsroadmap.com/physical/hair/zappriority.html ("If I had to choose between having a beard and having a penis, I would rather have the penis. It was much easier to get rid of than the facial hair.").

160. *When in My Transition Should I Start Hair Removal?*, *supra* note 159.

161. There are also practical reasons that can drive the desire to pass in public. As one trans-person comments:

> Discrimination frequently forces talented and qualified individuals out of their pre-transition careers, and makes it difficult for them to find new jobs. The individual whose facial hair or other characteristic makes it difficult to "pass" frequently faces even more discrimination than those who do "pass." Finding themselves unable to get any job whatsoever and unable to afford electrolysis, even talented and well-educated individuals sometimes find themselves in a downward-financial spiral which leaves only sex work as an alternative to homelessness.

Id.

162. *Electrolysis*, TRANSSEXUAL ROAD MAP (Jan. 4, 2011), http://www.tsroadmap.com/physical/hair/zapidx.html ("Passing as well as you can in your chosen gender will generally make your life much easier, since there are few things more disturbing to most people than a contradictory gender presentation.").

transgender patients mean, for instance, that insurers would also have to approve a biological female's request for electrolysis to permanently remove her beard and mustache growth? On what grounds could insurers deny this request, but still approve electrolysis claims from transgender patients? Until such questions are resolved, coverage of transition-related claims will remain limited and somewhat disconnected from the actual aims and purposes of transition.

D. Conforming to the Discourse of Disease

Despite the barriers that frequently impede access to adequate health insurance for transgender individuals, some policies cover certain transition-related services. A growing number of private employers explicitly provide health insurance coverage for transition-related procedures to their employees.[163] Transition-related benefits are typically self-insured by the employer who "puts money directly into a plan which then pays for the covered benefits when the claims are incurred rather than paying premiums to insurance companies."[164] Evidence that these employers are able to fund trans-specific healthcare at a relatively low cost has been instrumental to convincing other employers to include transition-related benefits in their health plans as well.[165]

Yet even when trans-specific health benefits are available, transgender individuals will likely find that eligibility depends on their ability to describe their gender identity within a specific discourse of disease. As Judith Butler points out, "most medical, insurance, and legal practitioners are committed to supporting access to sex change technologies only if we are talking about a disorder."[166] Butler describes the sequence of events that insurers generally expect to occur before they will provide access to gender-confirming treatment:

> A [gender] conflict has to be established; there has to be enormous suffering; there has to be persistent ideation of oneself in the other gender; there has to be trial period of cross-dressing throughout the day to see if adaptation can be predicted; there have to be therapy sessions, and letters attesting to the balanced state of one's mind. In other words, one must be subjected to a regulatory apparatus . . . .[167]

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163. "A survey conducted by the Human Rights Campaign indicates that about 120 employers provide coverage for transition-related medical services or treatments." *Corporate Equality Index 2011: Rating American Workplaces on LGBT Equality* 27, HUMAN RIGHTS CAMPAIGN (2011), http://www.hrc.org/documents/HRC-CEI-2011-Final.pdf.

164. Diskin, *supra* note 16, at 139 (*citing* HUMAN RIGHTS CAMPAIGN, TRANSGENDER ISSUES IN THE WORKPLACE, n.36). While this kind of "self insurance is a cost-effective option for many large employers, it remains out of reach for most small employers." *Id.*

165. Diskin, *supra* note 16, at 152.

166. Butler, *supra* note 62, at 288.

167. *Id.* at 287.

Medical discourse also plays a critical role in litigation attempting to secure insurance coverage for trans-specific healthcare. Courts that have ordered states or insurance companies to fund transition-related procedures emphasize the importance of medical evidence in reaching these decisions.[168] Medical opinion is often instrumental to favorable outcomes for transgender plaintiffs seeking insurance coverage. Cases involving insurance privileges for transition-related services all recount an almost identical and medically focused narrative. First, medical evidence is presented to confirm that the plaintiff has been diagnosed as a "true transsexual."[169] Courts define a true transsexual as someone whose biological sex conflicts with his or her gender identity in a very specific way; the court is confronted with either "an anatomical male with a female gender identity"[170] or an anatomical female with a male gender identity. Once it is established that the plaintiff "suffers" from transsexualism, the court will usually evaluate medical evidence to determine whether the treatment for which the plaintiff seeks insurance coverage "is the only procedure available for treatment,"[171] only considering the plaintiff's request if it is.

Obtaining coverage for transition-related care can also require rigid allegiance to conventional gender norms. Though non-transgender people who defy "assumptions and preconceptions about how men and women are supposed to behave, dress, and appear" are protected under federal sex discrimination laws,[172] transgender individuals attempting to secure insurance coverage to alter their bodies are usually expected to adhere to traditional notions of masculine and feminine identity. They must "completely . . . assume the [stereotypical] role of the opposite sex" through their appearance, demeanor, and sometimes even their sexual preferences.[173] One insurance company, for instance, will find sexual reassignment surgery medically necessary only when a member has "live[d] in society as a member of the other sex for at least 2 years" and "does not gain sexual arousal from cross-dressing."[174]

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168. *See* Dasti, *supra* note 15, at 1758 ("The explanation of transgender identities in medical and diagnostic terms is common throughout the case law, even in cases that do not deal specifically with sex reassignment surgery or sex designation."); Richard F. Storrow, *Naming the Grotesque Body in the "Nascent Jurisprudence of Transsexualism,"* 4 MICH. J. GENDER & L. 275, 279 (1997) (underscoring the pervasiveness of medical evidence in judicial decisions involving transgender people).

169. *See, e.g.*, Rush v. Parham, 625 F.2d 1150, 1153 (5th Cir. 1980); Doe v. Minn. Dep't of Public Welfare, 257 N.W.2d 816, 819 (Minn. 1977).

170. *Rush*, 625 F.2d at 1153.

171. Pinneke v. Preisser, 623 F.2d 546, 548 (8th Cir. 1980).

172. Kylar W. Broadus, *Employment Discrimination Protections*, *in* TRANSGENDER RIGHTS 93, 95 (Paisley Currah et al. eds., 2006); *see also* Price Waterhouse v. Hopkins, 490 U.S. 228 (1989).

173. Butler, *supra* note 62, at 279.

174. Clinical Policy Bulletin: Gender Reassignment Surgery, *supra* note 147.

Building a successful insurance claim for transition-related procedures has traditionally depended on one's ability and willingness to "perform" gender in a way that indicates "true transsexualism."[175] Conforming to this narrow conception of gender variance may help some acquire health insurance for gender-confirming care, but it comes with costs. Many advocates and scholars argue that the narrative recounted by those seeking transition-related services invariably frames transgender identity as a disorder that can only be corrected through medical intervention. This, they maintain, continues the historic pathologization of transgender identity.[176] Even if one can use the gender dysphoria "diagnosis as a pure instrument, a vehicle for achieving one's goals,"[177] others will be left with the impression that gender variance is a disease that must be treated. This is disturbing to those who view transgender identity as a natural, and even normal, variation of human sexuality. It is also offensive to those who reject the idea that insurance support should depend on one's ability and willingness to conform to a narrow definition of transsexualism and adhere to gender stereotypes. When only individuals who feel "trapped in the body of a person of the opposite sex" qualify for insurance coverage, insurers ignore the diversity of gender-variant populations and reinforce binary gender and sex paradigms.

By making gender-confirming treatment available only to individuals who demonstrate a prescribed set of characteristics, insurers also give transgender individuals incentive to frame their "symptoms" in a manner that will grant them access to desired interventions. Dean Spade describes "great, sad conversations with [other transgender] people who know all about what it means to lie and cheat their way through the medical establishment."[178] Procuring gender-confirming care requires "proving, through talk, that they have always felt, as far back as they can remember, like the gender other than the one they were assigned," even if their actual experience of gender variance was more complex or did not fit traditional gender stereotypes.[179] Ironically, there is no room for ambivalent or nonconformist ideas about gender norms when trying to access insurance coverage for transitional services.

Some transgender individuals have been savvy about circumventing narrow

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175. JUDITH BUTLER, GENDER TROUBLE 25 (1990) (describing gender as "performative—that is, constituting the identity it is purported to be").

176. *See, e.g.*, Butler, *supra* note 62, at 275; Spade, *supra* note 36, at 36.

177. Butler, *supra* note 62, at 280. Butler argues that even when an individual strategically uses diagnosis to access transition-related benefits, it may still lead to "a certain subjection to the diagnosis such that one does end up internalizing some aspect of the diagnosis, conceiving of oneself as mentally ill or 'failing' in normality." *Id.*

178. Spade, *supra* note 36, at 23.

179. Keller, *supra* note 15, at 54 n.17 (citing SUZANNE J. KESSLER & WENDY MCKENNA, GENDER: AN ETHNOMETHODOLOGICAL APPROACH 117 (1978)).

eligibility criteria and exclusions for trans-specific services. There is anecdotal evidence of transgender patients strategically employing treatment for an "acceptable" condition to obtain gender-confirming care. One trans advocate who documents such maneuverings writes, "many women get [hormone replacement therapy] covered through insurance as a 'hormonal imbalance.'"[180] This usually slips under the insurance radar even on policies that specifically exclude transsexual surgery and related services. Even complicated, expensive, and universally rejected procedures can be covered if one is particularly shrewd: "Some have been able to get face work tacked on as part of other corrective procedures. One woman writes she had her nose fixed during a correction to her jaw following a car accident. Another got her chin feminized as part of oral surgery to correct her overbite."[181] It is difficult for insurers to police this kind of behavior, particularly when healthcare professionals participate in efforts to "cover" transitional treatments with procedures that receive little scrutiny from insurance companies.

As this discussion suggests, the terms that currently define the limits of coverage for transition related care impose significant costs on insurers as well as policyholders. Coverage policies ignore the diversity of transgender health needs and encourage manipulation to obtain uncovered care. In consequence, the present insurance landscape reflects an inefficient allocation of transition related services. The next Part addresses how new national healthcare regulations may reshape this landscape.

III. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: IMPLICATIONS FOR TRANSGENDER CARE

The PPACA is the most sweeping piece of healthcare legislation passed in decades.[182] The PPACA and its companion bill, the Health Care and Education Reconciliation Act of 2010,[183] impose an ambitious set of reforms on the healthcare industry aimed at expanding insurance coverage while controlling medical spending. The media has repeatedly referred to the legislation as an "overhaul" of the American healthcare system,[184] and in certain ways, it is. For the first time in American history, insurance companies will have to comply with

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180. *Transition and Insurance*, TRANSSEXUAL ROAD MAP (Jan. 4, 2011), http://www.tsroadmap.com/reality/insurance.html.

181. *Id.* The site also comments that therapy for gender variance "is quite easy to get through [insurance] by listing it as 'depression.'" *Id.*

182. PPACA, Pub. L. No. 111-148, 124 Stat. 119 (2010).

183. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

184. *See, e.g.*, Stolberg, *supra* note 7, at A19; Janet Adamy, *Ten Questions on the Health-Care Overhaul*, WALL ST. J., JULY 21, 2009, at A16.

new regulations that prohibit denying coverage to those with pre-existing conditions.[185] Insurers will no longer be able to exclude individuals with particular health problems or vary their rates according to one's health status.[186] Up to 129 million Americans with medical issues that insurers may classify as pre-existing conditions stand to benefit from this new coverage mandate.[187]

Eliminating pre-existing condition exclusions, however, will not necessarily end discriminatory practices by health insurance organizations. Though insurers will not be permitted to deny coverage to particular populations outright, they will, in most circumstances, retain the right to refuse coverage for "medically unnecessary" procedures.[188] The necessity of medical interventions will likely be scrutinized more closely than ever before, since it is one of the few areas where insurers can still control costs and manage risk. When insurance coverage turns on medical necessity, however, transgender individuals almost always lose. Insurers have traditionally dismissed transition-related procedures as unnecessary and thus undeserving of coverage.[189] Absent further regulation of the insurance industry, transgender populations may gain expanded access to health insurance through the PPACA, but confront restricted access to care.

Part III of this Note argues that securing health benefits for transgender populations under the PPACA requires recasting the definition of medical necessity imposed by health insurers. Whether a given intervention is medically necessary is usually viewed as an objective question that turns on clinical need. Yet medical necessity can be more complicated than this definition suggests, particularly for transgender individuals. Certain medical interventions may be necessary for reasons beyond immediate health outcomes. Transgender individuals frequently seek transition-related treatment to access legal rights, secure economic opportunities, and abide by social norms. When medical interventions are the only way to achieve these goals, they are no less necessary because the outcomes sought are not strictly confined to health results. Medical treatments may, in fact, be even *more* necessary in this context.

A. Expanded Access to Health Insurance, Constricted Access to Care

As discussed in Part II, insurers have traditionally employed the presence of

185. PPACA § 1201, 124 Stat. at 156.

186. *Id.*

187. Amy Goldstein, *Study: 129 Million Have Preexisting Conditions*, WASH. POST, Jan. 18, 2011, at A1.

188. Under the PPACA, insurers must provide only "minimum essential coverage" to policyholders. PPACA § 1201, 124 Stat. at 161; *Id.* § 1302(a), 124 Stat. at 163. The PPACA does not actually define "minimum essential coverage"; the Department of Health and Human Services (HHS) has this responsibility. *Id.* § 1302(b), 124 Stat. at 163.

189. *See supra* Section II.B.

pre-existing conditions to deny or delay coverage or charge higher premiums.[190] The PPACA requires insurers to extend coverage on a guaranteed issue basis, regardless of an individual's health status: "[E]ach health insurance issuer that offers health insurance coverage in the individual or group market must accept every employer and individual in the State that applies for such coverage."[191] Rate discrimination based on health status is also prohibited under the PPACA to prevent insurers from simply increasing premiums to cover additional costs incurred by covering higher risk insureds. Under the PPACA, premiums may vary only by family status, geography, age, and tobacco use.[192]

Like other Americans, many transgender individuals will experience increased access to health insurance as a result of these reforms. Once the PPACA takes effect, insurers will be unable to discriminate on the basis of "any health status-related factors," defined broadly to include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and any other status-related factor deemed appropriate by the Secretary of Health and Human Services.[193] For transgender individuals, this means that they will not be denied insurance coverage or confront insurance rescission because of transgender status or prior receipt of transition-related services. Transgender individuals will also no longer have to pay higher premiums to access insurance coverage since the PPACA does not permit rate discrimination based on transgender identity. The PPACA appears to be, in many ways, "a huge leap forward for the transgender community."[194]

It is, however, unlikely that the PPACA will end discrimination against transgender individuals in healthcare. The new legislation restricts medical organizations and providers from practicing many forms of discrimination,

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190. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 has already limited the ability of insurers to include pre-existing condition clauses in employment-related group insurance policies. 29 U.S.C. § 1181 (2006); 42 U.S.C. § 300(g)(g). HIPAA "imposes a reasonably narrow definition of pre-existing condition (excluding, for example, genetic predisposition or domestic violence); it limits the look-back period for determining whether a pre-existing condition exists to six months; and in most instances, it only permits the pre[-]existing conditions clause to operate for a maximum period of twelve months." TIMOTHY STOLTZFUS JOST, THE REGULATION OF PRIVATE INSURANCE 28 (2009), http://www.nasi.org/sites/default/files/research/The_Regulation_of_Private_Health_Insurance.pdf.

191. PPACA § 1201, 124 Stat. at 156.

192. *Id.*

193. *Id.*

194. Press Release, National Center for Transgender Equality, Health Care Reform Signed into Law: How Will it Affect Transgender People? (Mar. 23, 2010), *available at* www.transequality.org/news10.html.

including that which is based on race, ethnicity, sex, age, and disability.[195] But the PPACA does not explicitly prohibit discrimination against transgender populations, even though these groups experience exceedingly high rates of discrimination in healthcare.[196] While this legislation may promise more healthcare rights to transgender individuals, it will not necessarily help them realize or guard these rights.

Furthermore, the new healthcare legislation does not protect access to transition-related health benefits. As discussed in Part II, insurers frequently deny coverage for transition-related care on the grounds that such care is not "medically necessary." The PPACA will likely continue this trend, unless the Department of Health and Human Services (HHS) issues regulations that designate transition-related care as an essential health benefit that every healthcare plan must provide. This is unlikely to happen, given the fact that none of the LGBT-related provisions from earlier versions of the healthcare reform bill are included in the final PPACA.[197]

Finally, there is a strong possibility that the new provisions enacted by the PPACA may worsen transgender access to healthcare. Eliminating pre-existing condition exclusions may lead to coverage of more people, but may also spur coverage of fewer services, at least for certain populations. Since pre-existing condition exclusions can no longer be used to deny coverage or charge higher rates to those with medical problems, insurers will undoubtedly turn to other measures to exclude high-risk clients and curb costs. To do so, insurers may increase medical-necessity review, particularly for treatments that could be considered cosmetic or lifestyle related. Once the PPACA takes effect, insurers may less readily accept a provider's conclusions about the medical necessity of a given procedure and more proactively impose their own narrow conceptions of medical necessity to avoid paying for certain treatments. Though politically sympathetic groups, like cancer patients or young children, might avoid increased scrutiny of the medical services they consume, the transgender population may not be as fortunate. Any coverage of transition-related care provided in the past may disappear altogether under the PPACA as insurers employ more demanding standards of medical necessity.

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195. PPACA § 1201, 124 Stat. at 156.

196. A survey by Lambda Legal found that seventy percent of transgender and gender-nonconforming respondents had experienced some form of discrimination by medical providers. LAMBDA LEGAL, WHEN HEALTH CARE ISN'T CARING: LAMBDA LEGAL'S SURVEY ON DISCRIMINATION AGAINST LGBT PEOPLE AND PEOPLE LIVING WITH HIV (2010), *available at* http://data.lambdalegal.org/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

197. Chris Johnson, *LGBT Provisions Cut From Health Care Reform Bill*, DC AGENDA, Mar. 26, 2010, at 20.

B. Recasting Medical Necessity

Insurers have long used medical-necessity arguments to restrict transgender patients' access to healthcare, and the influence of these arguments on transgender medicine may grow under the new federal healthcare legislation. This Section suggests that what is troubling is not medical-necessity review itself, but rather the *way* insurers define and apply medical necessity in making coverage decisions that affect transgender populations.

Insurers, along with most of the judicial and state actors that regulate them, have traditionally relied on medical criteria alone to determine whether a particular medical intervention is necessary and warrants coverage. As discussed in Part II, insurance plans regularly dismiss transition-related care as cosmetic or experimental, and thus unnecessary. Under the PPACA, insurers will have more incentive than ever before to narrow the kinds of services considered medically necessary, especially for politically powerless groups like transgender individuals. Also, as factions within the transgender community increasingly call for rejecting the pathologization of gender variance, it may become even easier for insurers to avoid funding transitional services on necessity grounds. Unless policymakers and courts intervene, transition-related care could disappear under the PPACA.

But why should these actors intervene? If even transgender individuals do not necessarily view transitional care as medically necessary, why should regulatory actors require insurers to include such care in their policies? The answer to this question depends on how one defines medical necessity. If medical necessity is a standard that turns strictly on how essential a particular treatment is to one's bodily or mental well-being, then transition-related care is arguably not medically necessary, since many individuals who identify as transgender can survive, and perhaps even thrive, without it.

Such a view of medical necessity is, however, somewhat myopic. Just because some transgender individuals do not need transitional procedures does not mean they are inappropriate for all transgender individuals. Patients with the same condition often have diverse medical needs, and interventions that are medically necessary for one patient may not be medically necessary for another. All individuals suffering from Lyme disease, for example, do not necessarily receive the same medical protocol, but we do not dismiss certain Lyme disease treatments as medically unnecessary just because every patient with Lyme disease does not utilize them.

Furthermore, a strict conception of medical necessity for transition-related procedures is inconsistent with the use of the standard in other contexts. As noted in Part II, a given treatment is usually considered necessary when a patient's physician finds that the intervention is medically appropriate for a patient's

condition.[198] Insurers and courts typically defer to the physician's judgment, provided it aligns with the medical community's recommended treatments for the condition. When insurers review claims for gender-confirming care, however, they are often less willing to accept a physician's conclusions about medical necessity.[199]

Finally, current medical-necessity review for trans-specific interventions rarely considers the significant impact social norms can have on the medical benefits these individuals seek. One scholar argues that transition-related treatment is important to "an individual's ability to function and survive in society, given current biases and beliefs."[200] Transgender individuals suffer high rates of discrimination in the workplace, and the current law offers little relief. In thirty-seven states, it remains legal for employers to discriminate on the basis of gender identity, and federal anti-discrimination laws do not cover gender-variant populations.[201] Anatomical features that deviate from what society considers "normal" can lead to severe harassment at work—that is, if one can even manage to hold on to a job despite transgender status.[202]

When the violence frequently encountered by transgender individuals is considered, it is difficult to dismiss transitional care as medically unnecessary. Reports of assault, rape, and murder of transgender people are fairly common and often brutal.[203] Victims frequently describe receiving little compassion from police officers and emergency medical personnel when reporting these crimes.[204] When even those responsible for protecting transgender groups from violence and redressing their harm react transphobically, concealing transgender identity with gender-confirming care may be, for some, the only way to avoid danger and discrimination.[205]

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198. *See supra* text accompanying note 134.

199. *See supra* text accompanying notes 136-137.

200. Susan Etta Keller, *supra* note 15, at 72.

201. *Fact Sheet: The Employment Non-Discrimination Act (ENDA)*, NATIONAL CENTER FOR TRANSGENDER EQUALITY (Aug. 2009), *available at* transequality.org/Resources/NCTE_ENDA09.pdf.

202. *Id.*

203. *See, e.g.*, Rebecca Cathcart, *Boy's Killing, Labeled a Hate Crime, Stuns a Town*, N.Y. TIMES, Feb. 23, 2008, at A11; Carolyn Marshall, *Two Guilty of Murder in Death of a Transgender Teenager*, N.Y. TIMES, Sept. 13, 2005, at A20.

204. Twenty-two percent of 6450 respondents in a national survey assessing discrimination against transgender and gender-nonconforming people reported being "harassed, physically assaulted, or sexually assaulted" by police officers because they were transgender or gender-nonconforming. Grant, *supra* note 2, at 158, 172 n.1.

205. Avoiding violence appears to be a significant factor in decisions to obtain transition related interventions. One woman writes, "As a pre-op trans woman who generally always blends and is read as cis, concerns about attackers turning murderous and emergency and medical personnel reacting transphobically are always mingled with any concerns about sexual assault.

Many will no doubt argue that social norms outside the doctor's office should play no part in determining what happens within it. After all, healthcare is designed to address medical issues, not social problems. Yet a system in practice often deviates from design and medicine is no exception. Whether we like it or not, social norms *do* impact our assessment of medically necessary procedures. Breast cancer patients who receive mastectomies for breast cancer, for instance, do not always require reconstructive surgery for clinical reasons. Yet federal law mandates coverage of breast reconstruction in connection with mastectomies.[206] For better or worse, breasts play a significant part in both personal and social understanding of female identity, so the desire to restore them after breast cancer is universally understood. Transgender individuals seek transitional care for some of the same reasons breast cancer survivors seek reconstructive surgery: to shape their bodies to match their personal identities and to simply fit in.

Along with considering the social necessity of treatment, medical-necessity review should take into account the legal implications of transition-related care. As Part I of this Note argues, the legal rights available to transgender individuals frequently depend on medical evidence demonstrating transition to a new sex. The ability to change gender markers on identification documents, to maintain the validity of a marriage, and to win custodial rights after divorce can turn on medical or surgical alteration of sex characteristics. Often, the medical interventions required to win legal recognition of an adopted gender are quite drastic; there are no states, for instance, that permit changes to the sex listed on a birth certificate without evidence of gender reassignment surgery.[207] As long as legal rights remain contingent on medical confirmation of sex change, medical-necessity review must take legal implications into account.

The obvious objection to this argument, perhaps from transgender advocates and opponents alike, is that incorporating legal analysis into medical-necessity review will strengthen the role of medicine in determining the legal understanding of gender. While we should not abandon efforts to make legal recognition of sex turn on factors other than medical evidence, the current law is not even close to divorcing itself from medicine in the area of transgender rights. In recent years, transgender advocates have focused on lessening, rather than

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Haven't really come up with any solutions for myself to handle the possibility other than get [sexual reassignment surgery] and don't be assaulted." Nicole, Comment to *We are the Dead: Sex, Assault, and Trans Women*, FEMINISTE (Apr. 12, 2010, 1:16 PM), http://www.feministe.us/blog/archives/2010/04/12/we-are-the-dead-sex-assault-and-trans-women; *see also* Donna, Comment to *We are the Dead: Sex, Assault, and Trans Women*, *supra* ("I have to admit that having had [sexual reassignment surgery] last year makes me a *little* less afraid of things like [assault and harassment] happening to me.").

206. Women's Health and Cancer Rights Act of 1998, 29 U.S.C. § 1185b (2006).

207. Spade, *supra* note 31, at 768.

eradicating, the influence of medical interventions on legal opportunities. One recent victory for the transgender community involves the State Department's decision to eliminate gender reassignment surgery as a prerequisite to alteration of gender markers listed on passports.[208] Though reassignment surgery may no longer be required to obtain a passport with a new gender, transgender citizens will still need a letter from their physician stating that they have received "appropriate clinical treatment" for gender transition.[209] This is clearly a victory for the transgender population, but it is a victory that remains contingent on medical evidence. Until legal rights are separated from medical authority, it is irresponsible to ignore the legal implications of care when reviewing the medical necessity of transition-related interventions.

CONCLUSION

The PPACA has revived social legislation in America and launched a new era in healthcare. Designed to guarantee healthcare access to all Americans, the new legislation eliminates the ability of insurers to discriminate against patients on the basis of race, sex, and even health status. It is not an overstatement to call the PPACA, as the President has, a "patient's bill of rights on steroids."[210]

It is important to realize, though, that the PPACA will not completely strip insurers of their authority to determine which individuals do and do not deserve care. New requirements will increase pressure on insurers to find other ways to avoid costly patients without prompting political backlash and additional regulation. An increased reliance on medical-necessity arguments to exclude certain procedures from coverage is likely, particularly if the value of these interventions is not widely recognized by the public or powerful special interest groups.[211] Transgender patients may find themselves subject to greater scrutiny for the health services they consume and may receive less coverage for transition-related interventions, which insurers are apt to find increasingly

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208. 7 U.S. DEP'T OF STATE, FOREIGN AFFAIRS MANUAL 1300 app. m (2011), *available at* http://www.state.gov/documents/organization/143160.pdf; *see also* Press Release, U.S. Dep't of State, New Policy on Gender Change in Passports Announced (June 9, 2010), *available at* http://www.state.gov/r/pa/prs/ps/2010/06/142922.htm.

209. Press Release, U.S. Dep't of State, *supra* note 208.

210. President Barack Obama, Remarks by the President to the House Democratic Congress, (Mar. 20, 2010), *available at* http://www.whitehouse.gov/the-press-office/remarks-president-house-democratic-congress.

211. *See* Jessica Mantel, *Health Care Reform: Setting National Coverage Standards for Health Plans*, 57 UCLA L. REV 221, 227 (2010) (arguing that though adverse selection will push most plans to offer only a minimum essential benefits package, politics will intervene to force coverage for some conditions). "Political considerations would lead politicians to push for an essential health benefits package that includes those conditions and treatments demanded by the public or influential special interest groups, regardless of the merits . . . ." *Id.*

unnecessary under the PPACA.

Heavier reliance on medical-necessity review, however, does not *have* to terminate transitional care for transgender patients. The PPACA grants HHS the opportunity to reassess and update the traditional interpretation of medical necessity by defining what constitutes essential health services under the new legislation. For transgender individuals, medical interventions are often critical to more than just health, so medical-necessity review should look beyond the clinical implications of care. Securing meaningful access to healthcare for transgender patients under the PPACA requires expanding medical-necessity review to account for the social and legal consequences of transition-related interventions. This is a pivotal moment for change in the definition and application of medical-necessity review for transition-related claims.